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Frameworks for Quality Health Care In Kenya

SIMON MACHARIA KAMAU



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Simon Macharia Kamau

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2018

Cover design –Writing a future-now health care contrasted with a congested dispensary

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Dedication

For Shirwil, Winnie and Mariane- My most excellent daughters who have often asked wonderful whys, and why nots. ‘You are a special enterprise on the part of God’

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First I want to acknowledge and thank all the people whom I have contacted since the idea of writing this book came to be some six or so years ago. You have been sincere, passionate and for all the right reasons want to see a change in the current situation in health care in Kenya.

I am proud to have lived and worked with all of you. The circumstances encountered by hundreds of our patients and health care providers provided insights I needed to understand and describe the health system. I would like to thank all the people in Kenya who shared their time, ideas and information that went into this book. It takes a great team of skilled and dedicated people to see a concept, and then turn it into realitythe kind of team I worked with in this project. Their commitment to higher-value health care has made this journey possible. ,

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I wish state that my insight was sharpened during my PhD Thesis in Medical Education Moi University entitled: *BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis: A Primer Model for Kenya.* In that case I wish to extend my unreserved gratitude to Prof Simon Kang'ethe, Head of Deapartment, my supervisors Dr Anne Ng'eno, Dr Franklin Boibanda and Dr. Joseph Choge. The background into nursing leadership in health systems stem from my Masters coursework at The University of Colorado Denver (USA). Thanks to Dr. Colleen Goode, Dr. Joyce Verran, Dr. Gayle Preheim, Dr. Betty Geer, Dr. Swathy Sundaram, Dr. Angela Richards. Dr. Sue Hagedorn, Dr. Roger Reeves, and Dr. Mustafa Ozkaynak. I am grateful for their perspectives and technical expertise.

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Mr. Elisha Okuto of Moi University Press who edited this work has a special place for seeing the gem in my work, believing in my work and without whom these ideas would have sequestered. You gave me the reason to put in some more. The publisher Compleat Health Systems [http://www.compleathealthsystems.com/] and Amazon.com for making it come alive.

My family (Grace, Mariane, Denis, Winnie, Shirwil, Alex) innumerable sacrifices contributed to the success of this project. To my fellowship at *New Testament Church of God-Modern*, under Pst Mikah Njoroge where I tested some of my thoughts. Finally, I would like to acknowledge GOD, for the gift of talent and diligence He bestowed upon me.

Foreword

Although the term quality might mean different things to different people, all are in agreement that we can easily recognize quality service when we see it. Everybody is looking for quality wherever they go. Quality is an attribute of a product or service that is superior and excellent that leaves one feeling that it was worth the reasons spent. In respect to health service, quality is that extra thing that one gets when they access health provision outlets and may make the difference in the disease outcome.

The history of quality started out with inspection, where a product or a service would be retrospectively examined for compliance to a standard. This gave way to quality control where all factors involved in producing a product or service were reviewed to meet set requirements.

Today, total quality management (TQM) is commonly used referring to organization wide efforts to continually provide a permanent climate to deliver high quality products or services to clients. TQM developed by W. Edwards Deming, shifted the focus of quality from adherence to a standard to satisfaction of the client. Deming insisted that this would only be possible when management accepted responsibility for building good systems with features and characteristics that have the ability to satisfy stated or implied needs.

In provision of health care, quality can thus be achieved when there are systems to ensure that the needs of those who seek medical care are satisfied. What health care seekers get must be reliable by delivering expected service right the first time and honoring set promises. For instance, the tests carried out must be accurate as compared to known control or gold standards.

Furthermore they should be precise, reliable, repeatable and reproducible. In this regard, repeated analysis on the same sample, under the same conditions at different times by different people should give similar results. Decision makers should be able to say that care and costing data are accurate, timely, appropriate, and reported in a useful manner. The leadership ought to be able to view the information in such a way that it supports their organization's ability to drive change.

Such quality service can only be achieved when service provision is responsive to the needs of the clients by ensuring that service providers are competent and accessible. In this regard, health care service providers communicate effectively and are trustworthy, honest and believable.

This book is basically a case study of Kenya, a resource limited country in sub-Saharan Africa (SSA). It is the believe of this author that Kenya stands out in the region in its efforts towards ensuring quality health care for its citizens, the challenges she faces are not unique but typical of many low income countries.

Access to quality health care in Kenya is not a privilege but a basic human right. Constitution of Kenya, Article 25 of the Declaration of human rights states that "Everyone has the right to a standard of living adequate for the health …and medical care..." Furthermore, article 43 states that "Every person has the right to the highest attainable standard of health, which includes the right to health care services".

Achieving the goal of provision of quality health services cannot be through laws, models or frameworks. Neither can it be a matter of chance. All must recognize that provision of quality health services is a matter of ethics, and embrace a deliberate strategy of ensuring development of a culture of doing things right the first time around to the satisfaction of the customer.

This book is about provision of such health services. Simon has written it in a user friendly manner from his extensive experience in the field. It will be an invaluable companion of people providing health care in a resource constrained environment such as Kenya.

Prof. Marion Mutugi, PhD, EBS

Deputy Vice Chancellor - Planning, Research and Development.

University of Kabianga, Kenya

Preface

The proposed constructs being introduced in this book are not complicated. They are borne partly of my exposure to quality issues as an Internal Quality Auditor in ISO standards (ISO13485:2003, ISO 19011:2002; ISO 9001:2008). The bulk of this work formed part of my studies: Masters in Nursing Leadership and Health Systems Administration at University of Colorado Denver and preliminary sections of my Doctoral in Medical Education at Moi University.

As a health care provider and manager who has worked in public health facilities in Kenya for many years, I have had the opportunity and privilege to see health issues from a variety of perspectives. I have delivered babies for hundreds of women. As a manager, I have tried to ensure that essential resources and support are made available to health care providers.

As a nurse educator 'I ensured instructors and the instructed did their bit, and rewarded them appropriately' (modified from the words of from Prof Lukoye Atwoli). I aspire to have better health professionals. As a student of nursing leadership, health systems and health policy I found my niche. I have endeavoured to explain the phenomenon that is quality health care provision in as far as its limit permit.

I will hardly scratch the surface but will share some of my experiences in over 25 years and *voices from the field* of many others serving Kenyans and frankly, from common sense. Chapter 2 refers to 5 typical stories: Lamoe, Nakoko, Mandera, Lokuruka, and Jila. Some of these have been painstakingly compiled and put together in first –person accounts as textboxes.

With some of this insider information I would be one of the health system's perfect positive critics. Hopefully by being high on ideals as well as substance. I am not an advocate for a particular interest group or point of view – indeed; some of my views elicit vigorous disagreement from health policy, medical education and nursing fraternities.

Hopefully, this position was not unique to this author; there is always an option of putting forward our ideas through sharing reflective notes we took along the way, a great deal borne out of disappointment. For many more who served in this caring industry the story is still being written. For the few fortunate ones it is read as they write.

"*There are things you perceive as self-evident, they are not always self-evident to everybody…you think there is evidence, you flog yourself to do them…you wonder why people are not seeing this… on a day to day basis there are too many initiatives which are pretty good that do not see the light of day…you record them in your memo and hope that someday someone will see them"*, Prof. Anyang' Nyong'o, during an interview at Harvard School of Public Health on Feb 12, 2014, when he was asked to describe the lessons he learnt as a Kenya's Minister of Medical Services (2008-2013). Later served as the 1st Senator and the 2nd Governor of Kisumu County.

It is easy to get discouraged, be negative, look for who or what to blame or make excuses for not doing our noble duty of serving those who seek our services. In line with these challenges, this book aims to nurture reflective practice, possibly suggest a cultural shift in each one of us even as we endeavour to offer the best service possible to our clients in

the area of our calling. This is because quality of care in resource limited settings has remained more of an aspiration than an accomplished outcome.

In the face of all these majority of health care providers were by nature, an unbelievably committed group, driven mostly by a strong sense of personal reward derived from helping sick people. For a good number of them this meant spending every working day in an inherently dangerous and unpredictable environment.

It introduces a framework, Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS). This is a new tool that encourages efforts that may be small but solve real problems faced by health care workers; as a way of introducing focused initiatives even when resources are in short supply.

From the outset it is good to state that it may not get us out of the hole we are in, but just like a number of others may be a stop gap measure. But, having seen the powerful effect that information has in changing the lives of Kenyans, there was need to share it.

The framework was developed in line with the call for development of trustworthy ideas for better implementation and outcome of Continuous Quality Improvement (CQI) activities proposed in Kenya Quality Model for Health, 2011. Section 3.2.3.4 of the KQMH document also encourages staff to generate a great number of improvement suggestions and show how these improvements can be implemented. Kenya Health Policy Framework 2012-2030 and a few other models that support the framework have also been reviewed.

Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) clarifies the need for careful observation in order to know what works under what conditions. It suggests that there will be quality practical indicator questions that could be asked on barriers/facilitators to access quality health care unique in the resource-constrained settings context.

It addresses the efforts of the care giver, referred to here as 'The Compleat Care Provider': who want to make their life count, make a difference, look forward to a better day, see possibilities, improvise and are innovative. Constantly searching for ways to do either this or that, with the interest of the patient at heart.

One who is an expert at workaround: a method for overcoming a problem or limitation in a program or system. Looks around and says - there is always something to use and does not want to look for excuses. Who envisions that there was a greater reward for their efforts and felt that they had value and a destiny. Had a 'Yes We Can' attitude and were fundamentally optimists. Believed in doing their best.

I believe that change is everywhere … but opportunity is here. It is good to add that things are the way they are, not how you would like them to be, unless one makes deliberate effort to change.

Mahatma Gandhi once said, "You must be the change you wish to see in the world" and Nelson Mandela's 'The time for change is upon us'. President Obama of US (and in his own words *"He was the first Kenyan - American to become The President of United*

States") said this concerning change, '…change will not come if you wait for some other person or some other time, we are the person that we have been waiting for'. Hon. Musalia Mudavadi said *'ebindo bichenjanga'* paraphrased from Kiluhya - never stand in the way of change, it changes.

On the other hand Dr Geoffrey Griffins (1933-2005), Kenya's renowned educationist and founder of Starehe Boys' Centre said this, "*This world is full of people who do their duty half-heartedly, grudgingly and poorly. Don't be like them. Whatever is your duty, do it as fully and perfectly as you possibly can…"*

Nevertheless the perspective adopted in this book is from the vantage point of the largest component of the health care workforce and a critical element of our health care system – the nurses. At some point using every day dialect and paraphrasing where necessary Anecdotal evidence showed that literally many treatments in hospitals were administered by the nurses who were clearly in control of the milieu.

Every metric on which hospitals (and healthcare for that matter) are evaluated – from quality outcomes; to safety; to patient satisfaction; to staffing efficiency; to medical staff confidence – were dependent upon having a staff of nurses who feel valued on the job. Why, because caring is a value-based concept in the nursing field.

Theoretically, patient satisfaction was connected with nursing care, nurses, and the organisational environment. Quality health care requires a nursing workforce appropriate in size and expertise and unconstrained in its ability to provide patient care safely. Therefore the text focuses on advancing their work in a complex system through leadership and vision.

Given the public's concern about health care in Kenya, the book concentrates on the accomplishments and failures of the system. Though I spent less time on successful features since they needed less attention. Seeing the shortfalls and gaps that exist was easy for most people, but putting this into context is another thing altogether.

According to Oxford Health Systems Collaboration (OHSCAR) – NDM 'inadequate health systems make many existing and potential future health interventions impotent. Nowhere are such effects more apparent than in Africa which continues to post the worst health indicators globally'. Nuffield Department of Medicine (NDM) had helped support an initiative that was working towards strengthening Health Systems Research in Kenya.

It is by recognizing the difficulties of the system that we can begin to fix its problems. The goal of this book is to help all of us understand the health system so that we can work better in the system and change what needs to be changed. Most of the issues explored would also apply to understanding health systems in other developing countries.

In exploring the many controversial issues facing the health sector, my opinion as the author inevitably colour and shade the words used and the conclusions reached. Some are based on the most fundamental values and perspectives I hold dear to my heart. This is because I believe everyone should stand to benefit from a system in which health care for all is accessible, affordable, and appropriate in its resource utilisation and of high quality.

Any inaccuracies in the book are entirely my responsibility. Any disclosures in this book do not refer to any one particular institution, while any such that may be misconstrued as such has been done, I believe with their best interests at heart.

It is my hope that this book will serve as a guide that inspires change and influence policy development process within the context of where it exists by providing uncomplicated direction for the complicated system called healthcare. The views expressed in this book are those of the author and do not represent those of their affiliated institutions or organizations or any other organization (s) for that matter.

smk

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Nairobi, Kenya

2018

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List of Acronyms

AHRQ- Agency for Healthcare Research and Quality

BCAOFR-CS - Best Care Anywhere Organizing Framework for Resource-Constrained Settings

CDF-Constituency Development Fund

CHAK-Church Health Association of Kenya

COBES-Community Based Education & Service

CMNLP-Comprehensive Nursing Practice Model for Rural Hispanics

CS - Cabinet Secretary

EBP-Evidence Based practice

GIZ-Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) (formerly GTZ)

ICU/HDU- Intensive Care Unit/High Dependence Unit

IOM-Institute of Medicine

ISO-International Organization of Standards

JASEML- Journal of African Studies in Educational Management and Leadership KAEAM- Kenya Association of Educational Administration and Management

KEPH-Kenya Essential Package for Health

KHPF-Kenya Health Policy Framework KQM-Kenya quality Model

KQMH-Kenya Quality Model for Health Kshs-Kenya Shillings, also KES

MOH-Ministry of Health

MDG- Millennium Development Goals NTV-Nation Television

PDCA-Plan, Do, Check, Act PFP-Private for Profit

PNFP-Private Not for Profit

SDG- Sustainable Development Goals

TQM-Total Quality Management

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CHAPTER 1

Concepts of Quality Health Systems

Overview

Health is both an end-goal of universally recognized benefit to humanity and a domain of human endeavour seeking to achieve that end. A *system* consists of component parts acting in unison to achieve goals not attainable by any subset of the components. The health system affects us all sooner or later, often in the most intimate and important ways. Yet, the workings of this system remain a mystery to most people.

Even many of those working in health care don't understand the basic features or functions of this system. This is unfortunate and unnecessary. It is essential that health care professionals & managers understand the structure and functions of their health care system. This is especially more for those devoted to delivering health care services to underserved populations.

The purpose of this chapter and by large this book is to help health care providers gain that understanding by providing them with an overview of the Kenya (a resource constrained setting) health system, its key components and their functional relationships. We have a choice between Kenya with health reforms and Kenya without reforms.

It is important that we discuss health reform; however, the understanding of health reform in Kenya especially following The Constitution (2010) implementation was still evolving amongst most of us (this author included), thus these materials will need to be brought up to date from time to time.

The chapter thus introduces the concepts of quality health that could be useful in resource limited settings. Certain key concepts are defined in the context of the proposed framework such as: compleat health care provider/team, resource limited, resource constrained or resource poor settings, quality health care, quality of health care, methods of paying health care providers, access to health care and accessible health. Some of these definitions have been borrowed from seminal works of experts in these fields.

It lays the ground upon which the fundamental nature of health care is given, which is characterized by people taking care of other people in times of need and stress. Health care is not just another service industry but requires a stable, trusting relationships between a patient and the people providing care. These are critical to healing or managing an illness.

Health care has been called one of the most complex sectors of the U.S. economy. Driven largely by robust innovation in treatments and interventions, this complexity has created an increased need for evidence about what works best for whom in order to inform decisions that lead to safe, efficient, effective, and affordable care. Any subject affecting the lives of so many and requiring such a large portion of our country's resources will continue to be a topic of debate, legislative changes, and politics not to mention market restructuring. As health care becomes more digital, information and datasets are

becoming larger and more numerous. These were notable observations made during 'Health System Leaders Working toward High-Value Care: Workshop Summary' (Alper & Grossman, 2014). Improving health system to make it become purpose driven will ultimately lead the next transformation in healthcare.

1.1 Introduction

It can be argued that no health system is perfect. The perfect health care system is like perfect health – a noble aspiration but one that is impossible to attain. "A health system consists of all organizations, institutions, people and actions whose primary intent is to promote, restore or maintain health" (WHO, 2007). World Health organization (WHO) is the directing and coordinating authority for health within the United Nations system.

It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

A healthcare system is a means of organised social response to the health conditions of the population. It is narrower than a health system and is often described in terms of the levels of healthcare and organisational structure of the Ministry responsible for health in most countries. In this book the two words are used interchangeably.

"A system is a group of interacting, interrelated, or interdependent elements forming a complex whole" (Heritage Dictionary, 2000). Globally, the healthcare sector was facing enormous challenges around both development and maintenance.

Many factors contribute to the need for changes in healthcare, including technology, government regulations, patient needs, and outcome measures among others. Currently it is having to deal with higher citizens' expectations. In healthcare, continual improvement is essential, and analysis of processes is an effective method to introduce changes to improve the quality of a product or service.

In Africa, the health sector was undergoing major policy, system, and infrastructural changes. Systems across the globe had and were experimenting with old as well as new approaches to "fix" their health systems. In efforts to improve access, improve service delivery, bend the cost curve, increase accountability, and improve responsiveness, to mention a few.

By 2005 Vietnam was ranked 187th out of 191countries with the most inequitable health care systems in the world. Tony Proscio (2011) explained some of this in his work with Atlantic Foundation in Vietnam since 1998 in a series of presentations 'First Treat the System' Promoting Health and Equity by Cultivating a New Approach to Health Care': *The funding lessons in public and/ primary health care.* Some of these lessons included that the government wanted to do things better, but did not know how. There was a need to build a culture of public health in the country.

It seems sometimes that many problems are solved just by planning, even if it is not the only area we need to improve since there are many other things. Having the perfect plan that we do not implement, or having the perfect plan to do the wrong thing, or having no plan takes us nowhere. In the case of Kenya, it is unlikely that we could admit that we do

not know how it happens, but it has been said on various occasions that Kenya is prided to have some of the best policies and strategic plans (at least on paper). It is about converting the intentions into results. It is great to have a strategic plan but the important thing is, do you implement it or is it gathering dust in some shelf somewhere? Sources indicated that between 70 and 90% of well formulated strategies were not executed (Jared Ouko in Captains of the Industry, *The Standard,* June 10, 2015 p 10. J.O is a leadership coach, speaker, author with Ken Blanchard companies).

Other times there was enormous discrepancy between the ideas, strategies and plans developed at the centre and their implementation in the field. Behind the strategic planning there was need for tangible deliverables. It might be farfetched but it might be that no other sector appears more fragmented, more crowded (as is evidenced by multiple stakeholders - sometimes with competing interests), more complex than healthcare in Kenya. This finding was somehow upheld by Post Conference report, (2014).

According to Porter O'Grady & Malloch (2015), value is determined by three elements: *cost, quality and service*. Cost means the available resources, which usually are in short supply in the health sector; quality which is partly determined by outcomes of care and; service which is a matter of time and type of care provided.

The orders the staff have been getting often become a conflict in themselves 'Provide quality care!' *but work with less staff to cut cost.* 'Decrease the spread of infection!' *but use/allocate less supplies to the units*…'Quality thus is linked to both cost and service.

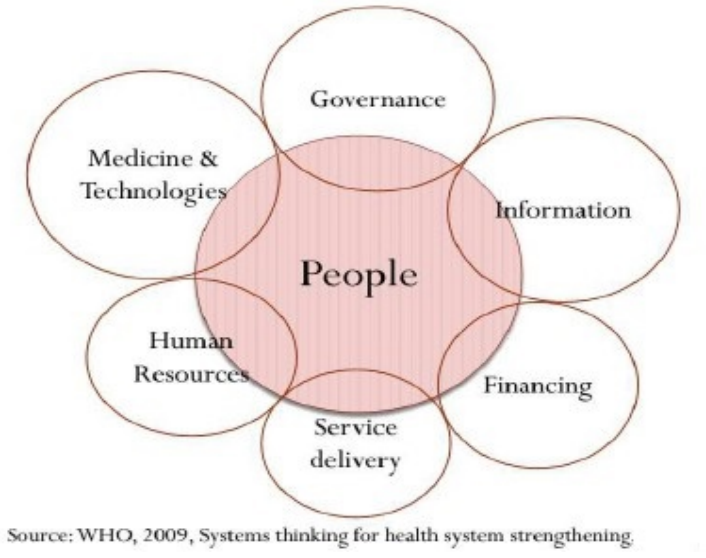


Figure: Building Blocks of Health Systems

Access to quality health care, its sustainability and continuous improvement are goals of the Kenya health care consumers. Health care is not just another service industry. Its fundamental nature is characterized by people taking care of other people in times of need and stress. Stable, trusting relationships between a patient and the people providing care can be critical to healing or managing an illness. This was a key statement in a record breaking report on quality healthcare by the Institute of Medicine (IOM) entitled *Crossing the Quality Chasm, 2000*. This author will keep on referring to it quite often.

The health sector in Kenya faces various challenges like disparities that exist across the country in terms of access to various components of health care. We therefore need to focus on understanding health inequalities from a research as well as from a service delivery point of view.

These include the challenges of extending health services to impoverished and geographically dispersed populations; providing adequate financing to maintain and extend health infrastructure at the national, county and sub-county levels; and ensuring the availability of health care providers where they are most needed.

Beyond grappling with a persistent high burden of infectious disease, including malaria, HIV/AIDS, and tuberculosis, Kenya faces an emerging problems characterized by increasing rates of cardiovascular disease, cancers, diabetes, jiggers, leprosy in children, bedbugs, plague, haemorrhagic fevers etc. We therefore need to understand how we can possibly influence positive behavioural change to obtain better health outcomes in some of these emerging situations.

A take on jiggers: during the *National Jiggers Day* held on 3rd March 2015, Kenya launched the national Policy Guidelines on Prevention & Control of Jiggers Infestation. Apparently, this was the first time that the government officially acknowledged the jigger problem, that 2 million Kenyans in 24 counties suffered jiggers (*Tungias penetrans*) a significant health and social economic burden which not only carried a social stigma but was debilitating as well. Ahadi Kenya Trust an NGO was spearheading anti jiggers campaign in all counties (see **Recognizing individual effort** in Chapter 2).

Emerging trends point to the fact that non communicable conditions and injuries/ violence related conditions will increasingly, in the foreseeable future, be the leading contributors to high burden of disease in the country, although the role of communicable diseases will remain significant.

This implies that future country policies will be faced with a high disease burden arising from cardiovascular disease, cancers, and diabetes among other lifestyle related diseases. An even more devastating reality, a new dawn has come that of living in a county with the prospects and consequences of terrorism.

All these might require embracing models that explain and predict the health-promotion components of the citizens' lifestyle. This was the theme of the 26th General assembly Federation of African Medical Students (FAMSA) held at Medical Education Academic (MEAC) Complex, Moi University, Eldoret Kenya from 16th to18th February 2011, was Burden of Chronic diseases in Africa.

The availability of basic health services, the frequency with which the services are offered, the presence of qualified staff, and the accessibility to health care among others contribute to client utilization of a health facility. Emphasis here is placed on the unique roles of health care workers, what they can strive to achieve for and on behalf of their clients.

1.2 Definition of Concepts

1.2.1 Compleat Health Care Provider/team

This book envisages a compleat healthcare provider or a compleat team of health care providers. The Merriam Webster Dictionary defines **compleat** as: having all necessary or desired elements or skills. Synonyms include: accomplished, ace, adept, proficient, complete, consummate, educated, experienced, expert, good, great, master, masterful, practiced(also practised), professional, skilled, versed. It is important to put it from the outset that perfectionism is not the point here – no project, situation or decision is ever perfect and so no one is.

He or she is the embodiment of soberness. Not necessarily one had it all together, what they do or don't do, but more related to attitude and giving a service beyond the obvious. Idealists and perfectionist is a farfetched description even of this author therefore to expect this about someone else would be unrealistic.

Nevertheless we should not stop dreaming of an ideal situation or person. A compleat worker is a gracious professional with a spirit that encourages doing high-quality, well-informed work in a manner that leaves everyone feeling valued. Doing their best work while treating others with respect and kindness. The team and not the individual worker is considered the basic unit in the workplace in healthcare (Porter-O'Grady & Malloch, 2015).

The concept of a compleat health care provider for the purpose of this model (see figure below, utilizing nursing as an example), it is assumed in this book that he/she will be receptive and be transformed by the constructs of this framework and be in a position to utilize it in enhancing access to quality health care in resource poor settings. Someone who can change some facts: like the notion that quality care is not possible in resource constrained settings.

The point of service drives approximately 90% of the decision making in a healthy and effective system, and therefore most of the decisions should be made by the workers located there (Porter-O'Grady & Malloch, 2015). Abrams (2005) cautioned on the implication of pushing the agenda of health care systems without taking due consideration to the health care providers at the operational level/point of service, "Bureaucratic health care systems, diminishing budgets, and burgeoning paperwork all alienate us in some measure from the purposes and products of our labours.

There are days when these conspire to deflate even the hardiest of good spirits." It is not heroes we are looking for in a compleat health care provider, not just someone who can make critical decisions quickly, but one able to apply good problem solving methods and mechanisms. Not staff with a 'fire fighting' mentality.

People who do not approach problems proactively acquire a fire fighting mind-set. Waiting for problems to manifest means being a day late and shillings short - by the time the problems are addressed, most of the damage has been done and will require nothing short of a hero to unravel.

Quoting US President Barrack Obama on why Africa needs strong institutions and not strong personalities. Persons who can transcend themselves, persons who can prescribe a far-reaching policy and institutional frameworks to strengthen the health sector in this country.

According to Porter-O'Grady & Malloch (2015) heroes make poor citizens and require a great deal of ego feeding to stop them going from hero to zero. They are not necessarily good models except in war, and can cause more problems than they are trying to solve. Instead it's someone who can act in situations that are ambiguous, underdetermined, unexpected or markedly different from their preconceptions.

Infact Mother Teresa said that, 'We can do no great things, only small things with great love'. One who has an intuition to anticipate crisis, risks, and vulnerabilities that may affect the organization, the employees and their clients. Being committed to resolving problems is not nearly as important as being committed to using problem solving techniques and processes. The following observations were made by facilitators in what might be one of the very few *compleat* forums by Kenyan health care providers.

"The challenge facing our health care system is not the lack of demand but the demand of quality and affordable healthcare", "I am convinced that it is possible to provide quality and cost-effective health care in a thoroughly professional but personalized way", "One thing that I'm not hearing people say is, 'I can't do it,'". "Instead, the discussions I'm hearing are focused on how we can become better at what we do as professionals and in collaboration with others to make a difference in their area". Infact, passion is leading one to say 'If I don't do it nobody else will do it'.

The staff understood the contribution they make. They were willing to look at ways to maximize resources and processes to improve value for patients, payers, communities they served, and the organization as a whole.

The compleat health worker may be patterned to the Caritas nurse [high scoring nurses on the patient Caring Factors Surveys (CFS)] who will provide an opportunity to understand and refine the work environment and processes to further promote caring and healing (Persky, Nelson, Brent & Watson, 2008). A worker with an attitude of continuously asking "what else can I do to rise above my circumstances, and achieve the results I desire?"

This is not to say we expect a perfect worker but to honour excellence, there is no perfect present to sustain. It has been said that fear of failure or retribution that employees feel causes them to essentially as some say in Kiswahili *wanatelekeza kazi sio kuitekeleza* paraphrased "retiring on the job" –who focus on noncore activities at the expense of the organisation, people who expect to be rewarded for simply showing up.

Further that 'expecting perfection eliminates the possibility of excellence' (Porter O'Grady & Malloch, 2015). At the same time we need to acknowledge like Mark Twain that good judgment comes from experience and experience comes from poor judgment. With this an important organizational dynamic emerges when leaders acknowledge that being right all the time is not even a possibility.

1.2.2 A Construct

A construct is an abstraction inferred from situations or behaviours. Abstractions of particular aspects of human behaviour and characteristics are called concepts or, in qualitative studies, phenomena. We can distinguish concepts from constructs by noting that constructs are abstractions that are deliberately and systematically invented (constructed) by researchers. The terms construct and concept are sometimes used interchangeably but, by convention, a construct refers to a more complex abstraction than a concept (Polit & Beck, 2012).

Constructs are the means for linking the operations used in a study to a relevant conceptualization and to mechanisms for translating the resulting evidence into practice. When referring construct(s) [in the proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) framework] it is assumed there is a fit between conceptual definition and operational definition. These will be addressed in greater detail in Chapter 6.

1.2.3 Resource constrained/limited Settings

Finding a definition for the concept a resource limited settings was challenging, as no existing definition would cover the full range of its meaning. One may therefore say that it comprises different interconnected concepts.

Turbulence

In one level five hospital in Kenya, those nurses who happen to be on duty during the transition period or visiting hours have to be very keen so that patients do not abscond. If they do and they often did (mainly these were Discharge-ins with unpaid medical bills) the nurse would be given hospital transport to go to the nearest police station to record a statement as soon as possible.

In yet another hospital if the patient escapes the nurse would have to pay the patient's bill by check off from her salary. 'It is worse that only the nurse is surcharged while other health disciplines are not'. One veteran nurse said it was now better since the security officer would also be paying. She disclosed that when a patient absconded she would 'lock up the rest, get transport to go to the police and report, even if it was at night'. Many times there was only one nurse on duty with so many patients, so nursing care would be left undone.

accreditation activities, performance targets, reports etc. There were several examples of such assignments in nursing including ridiculous ones like the ones above. Volutold was coined from compelled to do the job yet it added nothing to the pay check. Urban Dictionary describes it as forcibly volunteered. A task that was once voluntary has now been ordered to you.

It is not true that someone else cannot be trusted or become experienced in some perceived routine, mundane 'nursing and non-nursing' tasks that essentially drains the nurse's energy and time leaving less and less time for professional therapeutic nursing care. Nurses had taken it as a badge of honour to be jack of all trades.

Being proactive in exercising some boundaries and restraints was a must. Why should the nurse do unnecessary work, so many hours a week when they could work less and be just as productive, if not more? **Delegation** was covered in Chapter 17.

Therefore there are various approaches of looking at the concept of resource limited settings but generally the terms *resource limited, resource constrained or resource poor settings, low income settings* have been used inter-changeably. The first impression usually refers to some health care facilities in the rural parts of Kenya or elsewhere, some of which are run by the Ministry of Health or faith based organizations. But it could also mean certain areas within the same hospital that do not receive adequate supplies of consumables, medications and equipment.

Inefficient processes might lead to a lot of time and effort being spent looking for supplies by non-procurement staff like nurses creating a turbulence that distracts them from their primary role of patient cares (see **Turbulence** above).

Likewise, areas that appear neglected for any other reason(s) might also fall into this working definition. Tertiary public hospitals in many developing countries were unlikely to be spared from this definition either though the context may vary (see **The testimony of an exchange programme student** below).

A resource constrained setting might occur when leaders fail to appreciate that every element of a larger system is a system itself. A leader who is heading a particular service or department must see his or her role from the perspective of the whole system.

The best way being to look at matters as if the section head was leading the whole system from the perspective of the particular service or department (Porter-O'Grady & Malloch, 2015). Unfortunately this is not always the case for some Kenyan hospitals. Many organizations have suffered from the narrow focus of leaders who concentrate on their area of responsibility to the detriment of other component systems or the whole.

The testimony of an exchange programme student

Testimony 1

Although my electives placement was within a tertiary public hospital, I was still aware of economic constraints, particularly in the choice of drugs. One of the main reasons I am fond of the National Health Service in the United Kingdom is the fact that, in general, the same treatments are available to everyone, regardless of their economic status. I feel uneasy in situations where poorer people receive an inferior standard of care simply because they have less money.

Having said this, one has to work within the constraints of the system and do the best you can to help people within these barriers. I am glad that I put myself in this situation because, after all, this is how health care is organised in the vast majority of countries. 15'x15'. This incredibly tight space was cramped even more during rounds, when the team of 6 medical students, a pharmacy student, the attending physician, and my student colleague and I would huddle around a bed to discuss patients.

Testimony 2 *Patients did not have rooms, and curtain dividers were seldom used - so approximately 16 patients were grouped together in each block (8 beds per block, 2 patients per bed). On top of this, the apparent lack of nurses precipitated care of patients by family members, which meant 20-25 people were generally packed into an area that was about 15x15 feet.*

Some departments had even held hostage the whole organization with highly unilateral decision makers. As could happen when every nurse manager looks out for the interests of his/her department and staff, occasionally having to fight out with other departments to get what he wants for his own. In one such a hospital the overall leader was a paediatrics

specialist and so he favoured the paediatric division in an obviously skewed manner. In other situations the management focus on few programme areas, with others ignored /missed. [See **Forfeiting benefits to self for the common good** below].

Resource limited might also be a case of sponsorship with some areas desperately underserved while others have enough or more than. Consider this data while mapping the number of dispensaries in Kenya's counties per 10,000 people: Baringo County in the Rift Valley has 3.2 dispensaries/10,000 people, (the highest concentration countywide), while counties in North-Eastern have 0.0 to 1.0 /10,000 people.

The Constitution of Kenya 2010 introduced a devolved system of government which would enhance access to services by all Kenyans, especially those in rural and hard to reach areas. Further, the Kenya Health Policy framework 2012-2030 Section 5.2.1(viii) described such marginalized populations to include those in hard to reach areas of the country, those in informal settlements and most at risk populations.

The Constitution 2010 has provided for additional funding to previously marginalized counties like West Pokot through establishment of an Equalization Fund to pay for basic services which includes health services. But 3 years down the line (by June 2016), the fund had not been operationalized.

The human resource equation is also considered in terms of resource constrained settings; the patient workload that a staff - member can take care of safely. However, health professionals would need to weigh their duty to provide holistic care with obligations to their own health and that of their families in the event of extreme conditions, a statement by the American Nurses Association (ANA, 2010).

Apart from primary health care facilities facing significant challenges in levels of resources, health care workers could be said to be providing medical care in resource-limited settings where and if they frequently practiced with inadequate access to colleagues who possessed specialized training or resources.

In some of these locales, a single clinician may act as the obstetrician, paediatrician, and surgeon *cum* anaesthetist and frequently did so with insufficient information and resources to effectively address the broad range of health issues affecting patient care or the guidance needed from specialist colleagues (Basow, 2013).

Sometimes it won't matter that one was an intern. Many an intern will tell you that they will be working alone in these settings. Some of them may be ill equipped for these demands especially if they were not trained in the rural context. Apart from that, personal challenges were real for the staff in terms of: isolation, the struggle with work-life balance, career advancement, schooling for children, jobs for spouses and difficulty finding locums etc.

One clinician shared, 'If I had wanted to move my family away from the city to a rural/remote location, I'm sure questions along the lines of "Where's the nearest hospital/school/police?" would be asked. Naturally people choose locations precisely because they are close to the best school/hospitals/transport'. As a country it was as if we were using a health system designed for other countries, the tiny population of highly





The shopping centre in a fairer so to speak rural outpost: (Photos Sinoko area Kakamega courtesy of Charles N. Musee on Health Access Worldwide HAWI).
Kenya should establish a consortium like *Rural Health Information Hub* where staff from rural outpost can share their unique experiences https://www.ruralhealthinfo.org/topics/healthcare-access

trained staff were concentrated in the cities and big towns far from where 85% of the population lived in the rural areas, a big mismatch indeed.

Task shifting and on job training 'with no one to supervise you is no good experience' but it happens all the time in resource constrained settings. WHO (2008) came up with policy recommendations on task shifting *Rational Redistribution of Tasks* as a way to overcome some of these challenges.

Without having experienced the reality and challenges of rural practice the outlook as the sole health professional is something many would rather run away from a few weeks to months after reporting to the station (see **The empty dispensary** in Chapter 2).

When the government does not actively regulate the number, type, or geographic distribution of its health workforce, deferring to market forces instead. Some areas of this country for various reasons (not the least of which is insecurity) fail to attract health professionals of all kinds, creating true primary care deserts.

Resource constrained setting might also mean staffs are less available at the work place and working. The *Hivos* study 2013 covered in chapter 2 agree with several other studies before it that showed absenteeism and even when present providers spent less than half of their time in patient care. Increasing the productivity of existing workers is almost always more cost-effective than hiring more workers, and in many resource constrained settings, hiring more providers may be impossible.

It might also mean a setting where safety is not usually a *First* consideration due to several competing issues or utter sloppiness. The Kenya Patient Safety Survey 2014[1] published by the Ministry of Health in February 2015 (conducted in partnership with World Bank, World Health Organisation and the Danish SafeCare-PharmAccess).

The report stated that, "overall safety compliance was relatively poor, with less than one per cent of public facilities and only about two per cent of private facilities achieving a score greater than one in all five areas of risks assessed."

In this survey, facilities were graded on an ascending score of 0-3, reports. Only 13 of the medical facilities gained a score of more than one of the scale. 11 out of those 13 that scored above a one are private facilities. Less than six per cent of public hospitals achieved a score greater than one in having a competent and capable workforce.

The report cast doubts onto the quality of medical care in some hospitals in Kenya as it showed that a patient's safety was not guaranteed within medical facilities and hospitals. The most problematic of the evidence came from only 13 out of 493 private and public hospitals gaining a passable score.

This report on safety at hospitals emerged on the backdrop of the Ministry of Health's admission that human error was responsible for the paralysing of the 28 children in Busia County who fell sick after an injection(s) gone awry (see **Akichelesit dispensary** below). More recently (Jan 2018) in Bomet County after measles injection.

[1] *www.health.go.ke/.../**Kenya**%20**Patient**%20**Safety**%20**Survey**%20Report*.

Akichelesit dispensary

Akichelesit dispensary is located north of Teso, Busia County in western Kenya. It is a public Health facility that served a total population of 10,251 people, with a monthly workload of 4500 cases on average and a daily attendance of 150, malaria was the leading condition among out-patient morbidities. It conducted 4 deliveries on average every month, with an average ante-natal attendance of 70 clients.

The main source of drug supply was Kenya Medical Supplies Agency (KEMSA) while other sources included revolving fund pharmacy run by AMPATH. The dispensary was managed by 3 nurses and 1 lab technician

(Source: Kenya National Union of Nurses in *Findings of the Alleged Injection Associated Neuritis in Children at Akichelesit Dispensary*).

This Akichelesit incident caused a public outcry when the news came out around July 2015. These were among the numerous cases of alleged medical negligence. Several theories were postulated including: injection neuritis with foot-drop, possibility of contaminated drugs, injecting *Quinine* into the wrong site. Even polio had to be ruled out.

Whichever might have been the case, concerning the culpable health care provider, *nothing could be worse than being honestly and sincerely wrong*. Or *to know the wrong thing too well*. The 28 were airlifted to The Nairobi Hospital for specialized treatment. 13 of the 28 children were later discharged from the hospital walking and in good general condition one month later.

There is what might be referred at the operational level (in clinical area settings) as 'clearing and forwarding'. Doing work to finish the shift with little concern for detail or quality. This is something the KAIZEN 5S 1K (*sort, set, standardize, shine, sustain, keep it up)* program of total quality management has tried now and again to address, some gains have been realised in some centres but for a good number a good Kiswahili word for this environment or worker is 'shagalabagala' for: chaotic, messy, disorganized, anyhow.

Otherwise how does one explain a setting whereby less than adequate decontamination and sterilization practices still exist despite written protocols, mechanisms and supplies to facilitate them being generally available?

I would be accused of being unrealistic as if these things were widely available when they were not. Things are never as easy as they seem; however, with some of these practices it seems there are those that barely try (see **Clean gloves or sterile gloves** below and **The ideal** in Chapter 17)).

'Unattended delivery is unattended delivery whether it's happening in hospital or out of it… (if mothers are so many and you are so few or alone) in case of a complication which mother do you attend to?' These were the words of Dr Nelly Bosire an official of Kenya Medical Practitioners & Dentist Union (KMPDU) Nairobi branch during a panellist discussion *Checkpoint* in one of Kenya's television.

The interview focused on Pumwani Maternity Hospital where the ratio was 1 nurse to 10 mothers in labour ward which had 9 cubicles and 2 infant resuscitaires (WHO recommends 1:1).[2]

It was noted that with the introduction of free maternal health in June 2013 the number of women seeking health care at Pumwani Maternity Hospital had increased by 60%, (80 to 100 normal deliveries and 20-24 caesarean sections a day) while the staffing levels remained the same.

Clean gloves or sterile gloves

Subscriber JK posted on KNUN wall on 27th January, 2015, *'... VE is done na 'sterile gloves? Hio nilisoma Cole but hosi za gava ni clean gloves period! Sterile zinapatikana theatre. lol!' Paraphrased these word from Sheng (Swahili-English dialect spoken among the younger generation) in other words mean '...that vaginal examination is done using sterile gloves? That was what I learnt in college, but in government hospitals the procedure is done using clean gloves period! Sterile gloves are for the operating theatre use only, amused (lol - a colloquial form for laughter on social media, here used as antonym for sarcasm)'.* VN posted on Kenyan Nurses Forum 24th March 2018, *'dressing of wounds with clean gloves, clean gauze, clean instruments is wrong...'*

A follow-on thread by BE to the earlier post by JK, *'sometime you conduct a delivery without a delivery pack. It's practical'. Or 'use a surgical blade for/as an episiotomy scissors. Chilling*!'

The following incident short of abridged these 3 accounts. *Five years ago in one such facility, nursing students had come up with their own contraption of 3 delivery sets solely for their assessment, this went on for some weeks. As long as there were assessments, the packs would be available, mainly applying to the particular case of the assessment. After the exams were over, the sets ready for the next delivery remained uncollected in the sterilization unit up to 3 days. All this time mothers continued to deliver 'the usual way'. There was loss of count on how long the status quo remained.*

Again how does one explain a situation whereby a contraption in the name of an ambulance with a critically ill patient on referral will set out on a trip with the crew knowing too well that it lacks in any form of emergency or resuscitation equipment and supplies. Nor does it have a torch, neither a jack nor a spare wheel? In one such scenario a couple of years ago this was what was covertly shared by one of those who witnessed it (see **The ill-fated escort** below and **Shot and left for dead** in Chapter 2).

How do we explain the circumstances of the ill-fated escort: the hands off, the gaps - a referral escort without a qualified staff; en-route transfer medication, resuscitation & stabilization of the patient; the more than 3 hours delay; the deteriorating patient's condition; at whose expense were the nursing students offering the services they did; what about the sickly ambulance?

It continually had become common knowledge that interns (Clinical officers or Nursing) were the ones who did this kind of work in our public hospitals, the question remains whether they would be a better option for the critically ill (See **To have one of our own** in Chapter 3 and **The ill-fated escort** below **18 hours' ambulance ordeal** in Chapter 4).

[2] KTN Checkpoint 2100Hrs. 7th June 2015; Available http://www.standardmedia.co.ke/ktn/?videoID=2000093919&video_title=women-at-risk-over-pathetic- state-of-pumwani-maternity-hospital

The ill-fated escort

Two 3rd year nursing students escorted a head injury patient who needed specialized treatment from a lower level to a higher level hospital. The referral note indicated a Glasgow Coma Scale (GCS) of 15/15 upon setting out at midday. This was expected to be a 4 hour journey under ordinary circumstances. The ambulance had some mechanical problems along the way but with some 50Km or so to go, the ambulance broke down, they contracted some public means (popularly known in these settings as a Probox) for the rest of the journey arriving at the destination hospital at 7.30pm.

The GCS was now 3/15 (for your information this is the lowest possible score, while 15/15 is the highest possible on neurological assessment, anything 8/15 and below - prognosis is guarded) *patient was admitted into the critical care unit. Not to mention that it took the students almost 24 hours to make it back to centre using their own money after it became clear that no help would be forthcoming soon, the ambulance was grounded for a couple of weeks.*

More than enough *God forbid* examples are all around our health facilities. Thanks to the county governments, the ambulance(s) status had remarkably changed in less than five years since devolution. Bomet County perhaps led in terms of efficiency, especially since it had outsourced the services of Kenya Red Cross. Conducting a Root Cause Analysis or a Failure Mode Effects Analysis needs to be adopted as an organizational culture for quality improvement to prevent such occurrences in the future.

Resource constrained setting could also mean constrained space to work in. Many county hospitals had failed to expand in terms of space. There is a greater need for public land with many competing powers including private developers. Today we have a higher demand for women seeking to deliver in hospitals under the care of a trained health care provider but there has not always been corresponding effort to expand the maternity units and especially labour ward (Please see **The delivery room** in 3.1).

According to Porter-O'Grady & Malloch (2015) not adequately accessing additional resources or adjusting the focus of existing resources in a timely fashion creates a double demand on staff, further burdens them with additional work, increases their levels of emotional stress, decreases their ability to focus and respond to immediate issues of concern. The staff's inability to respond and the narrowly allocated resources with no financial flexibility creates a serious constraint on the organization's ability to respond to crisis.

Should the emphasis by the government, employers, insurance providers and individuals be improved health rather than provision of additional medical services, which will lead to new approaches to improve health (Feldstein, 2011 p37)?

Imagine of a pyramid which is the Kenya health system, the size of our economy and the trajectory of where we are putting our money:

> Rather than focusing on population-based services such as health education, immunizations, etc., which are at the bottom of the pyramid (the largest section that should in-theory make-up the most of health care services), we are focusing more on treatment (and we want to go for the invasive treatment or the more-so tertiary) which is at the top of the pyramid (the smallest section that in theory, we should devote the least time and resources to in health care).

> I say in theory because that is what it is – a theoretical, in practice we seem to prioritize more resources for the benefit of fewer people in the shiny projects.

We seem to nolonger desire to invest in health rather than invest in 'patching people up' (in critical care, renal replacement therapy, cardiac catheterization labs etc.). Are some of these projects priorities only to the extent that they are fulfilling political manifestos? Responsible leadership ought to perpetuate ongoing projects as well as come up with new ones.

A resource limited settings like ours cannot afford to drop what we have been working on in favour of new ones with every change of guard. Where is the trade-off for an economy like ours? (See **More services *vis-à-vis* improved health of the services** below).

More services vis-à-vis improved health of the services

I had a discussion with this health care services manager of a 205 Beds and 17 cots sub- county hospital, we shared on a number of things. One was the need to have another female ward to decongest the only female ward in the hospital (apart from the maternity and labour ward). It housed medical, surgical and gynaecological patients. The hospital had one male ward and one children's ward. After a lengthy discussion she disclosed that the priority for the hospital was an ICU and they had already sent staff for training on the same. Why was this the case? The manager said that the hospital received the same number of patients as the county hospital which was some 36 km away.

[This author reporting on an encounter with a health care services manager]

"The county health department does not understand our priorities. Instead of buying a lot of ambulances they should have hired more staff for us. Instead of building a mortuary they should have built for us another ward, or an extra theatre for maternity", Senior manager, Hospital 'A' (Barasa *et al.,* 2017: *Recentralization within decentralization: County hospital autonomy under devolution in Kenya*).

1.2.4 Beds and Cots

'Figures do not lie': But about number of beds and cots in our hospitals they could lie. The following postings from an online discussion and a media expose attempted to interrogate this point:

> *…may be maybe not about the interpretation of cots vis-a-vis beds. If you allow us go our way we will tell you that there are coaches, stretchers, wheelchairs, incubator and even benches and the floor where a sizeable number of our patients and lay care givers sleep in the hospital every day.*
>
> *We will even tell you of bed sharing by two or more patients as a fair norm in our public facilities. No cot (and I suppose a number of healthcare providers in the class will attest to it), no cot belongs to one child at least in Kenya. The is no substitute for a bed in a hospital when the patient needs one and we don't have enough.* But then *if more beds are not an option, what else can we do?*
>
> *There is nothing like holding capacity in our public hospitals, transport, prisons et cetera. Allow me to philosophize about a basic fact of bed/cots: ours is a typical case where figures lie. There is always room for one more; after all where else do we want them to go? And so we ease our space for them, 'coz who knows I could*

> *be the next one in need of same kindness. So we reciprocate and the cycle continues.* (Online discussion on Geographical Information System for health researchers) (see Zusha in Chapter 6).
>
> *Mothers who have just delivered have to take turns to sleep as they share beds… a 24 bed ward in one sub-county hospital had up to 40 patients with the tiny beds hosting up to three patients. 'Sometimes we take turns to sleep allowing whoever has come from the delivery room latest to sleep first' one mother said. Indeed, each bed has two or three mothers seated, unable to lie down no matter how tired and uncomfortable they were.* (J. Kubania, State of Health, July 24, 2015 *County* pp25, *Daily Nation*).

'…and we need more space: the patient does not get rest because of all the visitors. It is as if five or six extra people are with the patient. The hospital ward looks like a market place. Even the football team is coming to hospital if a player is hurt' (Fuglesang, 1982). Consider the many patients who were on the floor, corridors of the ward and imagine a 'Future now health care - digital care contrasted with congested *market like* ward'.

What would be our role in improving the availability of the beds we have - both directly and indirectly?: through helping people go home if they don't clinically need to be there, through getting developing conditions attended to before they need a bed, and planning around bed usage, so they're not idle while people need them, and the right kinds of beds are available to match demand.

We should always communicate well our intentions for a patient to avoid being at loggerheads over patient admission levels. Would it be possible for example to forecast a discharge date, so that all the non-clinical things that need to happen can be planned with that timeframe in mind - rather than started after the clinical discharge decision is made?

1.3 The Concept of Quality

Quality and safety are inextricably linked. *Quality* in health care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety (The Joint Commission International for Accreditation, JCIA 2015). Patient safety emerges as a central aim of quality.

By October 2016, The Aga Khan University Hospital became the first institution in Kenya to get this status. Even then meeting one count: infection free environment which is just one of the over 1000 JCIA measurable elements. In their own words 'this makes keeping out the bugs a daily obsession'.

Patient safety, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. Safety is what patients, families, staff and the public expect from health care organizations.

The concept of quality and the benefits that would be conferred to the health providers' work and the outcomes for their patients have not been completely understood by health managers and providers in Kenya (KQMH, 2011), yet patients were becoming increasingly aware of inadequacies regarding quality within the health care system. In a personal communication to this author, Annette Eichhorn-Wiegand, a Quality Health Management Systems Advisor with Christian Health Association of Kenya (CHAK)

observed that,

> *The confusion in Kenya is far too large as every donor brings in its own quality system and as people have very little background of quality management and how the different models and systems are linked and married, it is often difficult for them and confusing*. There were conflicting requirements of donors and government managers in some cases.

Aaron Donabedian is one of the most widely recognized expert on quality health care research. He defined quality care as "that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend to the process of care in all its parts" (Donabedian, 1990).

Quality health care is a human right for all according to American Nurses Association (ANA, 2010). They added that to improve the quality of care, healthcare professionals must address these complex issues: increasing costs of care; health disparities; the lack of safe, accessible and available healthcare services and resources.

According to Porter-O'Grady & Malloch (2015), there was a general belief that health care is expensive, is not safe and that the quality outcomes are less than desirable. If that comment was about the US, where does that leave those in the developing countries? Achieving the highest quality health care at the lowest cost is such an admirable but elusive goal.

Peter Senge (1999) on the other hand defined quality as;

> *... a transformation in the way we think and work together, in what we value and reward, and in the way we measure success. All of us collaborate to design and operate a seamless value-adding system that incorporates quality control, customer service, process improvement, supplier relationships, and good relations with the communities we serve and in which we operate - all optimizing for a common purpose* (Web2. Concordia).

Definition of quality generally then could be:

- *Conformance* to specifications measures how well the product or service meets the targets and tolerances determined by its designers
- *Fitness for use* focuses on how well the product performs its intended function or use.
- *Value for price* paid is a definition of quality that consumers often use for product or service usefulness.
- *Support services* provided are often how the quality of a product or service is judged. Quality does not apply only to the product or service itself; it also applies to the people, processes, and organizational environment associated with it.
- *Psychological criteria* is a subjective definition that focuses on the judgmental evaluation of what constitutes product or service quality.

1.3.1 Quality of health services

According to WHO quality refers to the extent to which the health services being delivered are consistent with good medical practice. Definitions of the quality of health services according to community perceptions were reported in a study carried out in rural Uganda by Kiguli *et al.,* (2009). For them quality depended on a number of variables related to technical competence, accessibility to services, interpersonal relations and presence of adequate drugs, supplies, staff, and facility amenities.

A summary is provided of the outcomes from the study (Please see Appendix 1). There is also the "service" aspect of quality, the element of what is often referred to as "responsiveness", and is an important element of any health system. Quality of health services can also be looked at in terms of how practice varies across health facilities.

Another local angle cited here is from Maua in Meru County, 'In Maua Methodist Hospital we define quality care or services as "doing the right thing, in the right way, at the right time, to the right person, using the resources available,"' as shared by Muriuki & Gitari (CHAK, 2013) (Please see Appendix VIII). Indeed this definition plays quite well into the context of the proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) as it underscores the vital role of what would be available in terms of resources.

Most quality measures had been designed to measure evidence based care which rarely is the case in most resource constrained settings of Kenya. Even in developed countries like US, Agency for Healthcare Research and Quality (AHRQ) report admitted that quality health care varied depending on where one lived (AHRQ, 2005).

Poor service quality was widespread in many health systems, in part because there was great uncertainty in medical practice, but also because sometimes clinicians simply made mistakes or just did the wrong thing. In addition a lack of resources for medicines, salaries and other critical inputs, as well as low health worker motivation, can all contribute to poor quality health services.

For so long Kenyans had witnessed a health sector that allegedly had been managed by intrigue, whimsical approaches rather than following policies, structures/processes and continued improvement. There was a good number of frameworks and policies gathering dust.

The Constitution 2010 promulgation transitioned Kenya into a devolved system of government with a central government and 47 semi-autonomous county governments. This came into effect after the March 2013 general election.

The aspirations by Kenyans had been that it was about time to put in all the spanners in the works to assure quality health care is a reality. Chapter 3 of this book deals with aspirations of Kenyans. Generally other chapters captured the trajectory through the first 5 years which should be considered as early experiences.
However, the scene became complicated with changes in hospital autonomy over five management domains: strategic management, finance, procurement, human resource, and administration (Barasa *et al.,*2017).

The cited study above examined changes in hospital autonomy as a result of devolution, and how these had affected hospital functioning. They interviewed county health managers and hospital managers mainly at the coastal region of Kenya. It provided very good insights into the effects of decentralization on the autonomy and functioning of hospitals.

1.4 Access to quality health care

Most governments worldwide would like to declare that their citizens should enjoy universal and equitable access to good quality care. However, even within the developed nations like US, this goal is difficult to achieve, and there are almost no internationally recognized standards on how to define and measure "equitable access" (Mossialos, 2004). These are issues we cannot run away from.

The concept of access to health care described in this book has two or so major components: ability and availability. The first is ability to pay but availability is equally important. It is a decision that can revolve around a pool of factors depending on the individual.

But generally of priority being health status, attitudes/perceptions, ability to pay, transportation, etc. usually in that order. Most importantly, the price of a service! The decision to seek a medical service in a nutshell will depend on the value placed on that service by the consumer (patient) in relation to the cost of that service.

According to Bodenheimer & Grumbach (2012):

> Availability of health care personnel and facilities that - are close to where people live, accessible by transportation, culturally acceptable and capable of providing appropriate care in a timely manner and in a language spoken by those who need assistance.
>
> Access to health care is most simply measured by the number of times a person uses health care services. Also can be quantified by surveys in which respondents report whether or not they failed to seek care or delayed care when they felt they needed it.

We need to appreciate that health care was essentially expensive. For example, it took between 7 to 14 years of research and come up with a drug; these costs get transferred to the consumer. Let's consider equipment - a piece of MRI (Magnetic Resonance Imager) cost anywhere around Ksh200m to purchase. Add operating costs and maintenance, and a 10 year lifespan. It generally cost the patient Ksh18,000 - 25,000 currently for an MRI scan (NHIF met Ksh 8000 -14,000 with some out of pocket to the patient).

How then do we make it available and accessible to everyone at the lowest level and system wise? Ensure a seamless health system that builds trust in the public that they can get the health care they needed. This brings us to the next point – the ability to pay.

Ability to pay: Generally speaking, there was a strong association between poverty and ill health. Wealthier nations and wealthier individuals enjoyed better health as measured by a variety of indicators such as life expectancy. If one can afford a service, they can most certainly obtain it! As people become wealthier, the theory was that they tended to spend more on quality medical services, they often saw specialists more, paid more to wait less or see a provider - sooner, etc. (Fieldstein, 2011; p 49).

"Having insurance changes a person's behavior". If someone has insurance medical cover, they are likely to utilize more services just because they have that insurance (Fieldstein 2011; p.55).

About four of 10 (39%) adults with below-average incomes in the US reported a medical problem but did not visit a doctor in the past year because of costs. More than one-third (37%) of U.S. adults reported forgoing a recommended test, treatment, or follow-up care because of cost. This is not just a matter of access but also of equity and affordability.

Equity in health service use means, simply, that individuals that need a particular health service are able to get it. If health systems are to make the most progress towards UHC given the funds available, the amount of health services a person uses should reflect their need and not other factors, such as their ability to pay, or where they happen to live.

To illustrate equity in service use: data about the extent to which pregnant women deliver their children in the presence of a skilled health worker, in other words with the relevant obstetric skills. From a health perspective, the need is clear: all women should deliver in the presence of a skilled, trained health professional.

But this is not always the case in developing countries. In this case a skilled birth attending to the delivery thus is not determined, or relative to, the woman's health needs but rather a range of other factors.

Data drawn from among others *The Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults*. "Sicker adults," were defined as those who rated their health status as fair or poor, received medical care for a serious chronic illness, serious injury, or disability in the past year, or were hospitalized or underwent surgery in the previous two years. If that could happen in the US then it's not hard to imagine worse situations in resource limited settings of sub Saharan Africa.[3]

According to Gulliford and Morgan (2003) access was concerned with whether those who need care could gain entry into health care system. They observed that those with the greatest health needs experience less access to preventive services, primary care and secondary care.

Components of quality health care as identified in a WHO publication edited by Roemer (1988) on Primary Health Care were a combination of *access* (whether individual could access health structures and processes of care that they need when they need it) and *effectiveness* (the extent to which care delivers its intended outcome and results). When consumers have concerns regarding quality, they may question equity of service, quality, standards, distribution, allocation and consistency of the quality of service.

Equitable access does not necessarily mean equal travel times for all services or that all services are available locally (Berwick, 2012). According to Berwick the principle expectations of quality of care in rural (as well as urban) areas ought to be equal for non-emergency services providers choose to deliver. Residents of small rural communities often have to travel further to see specialists because take or leave it, there too few residents to support some specialties.

[3] The Commonwealth Fund. New York, NY, June 16, 2014 http://www.commonwealthfund.org/publications/press-releases/2014/j...

The relevant benchmark for emergency services for a rural hospital would be if the rural hospital nolonger offered emergency services and patients must travel farther for emergency services (Berwick, 2012). While these were findings may be true for the US where this report emanated, it may not be so for our case since it would appear unfair to determine access by accounting for levels of staff, patient volume and technology etc. Just for example how many gastroentologists or oncologists for that matter can rural (as well as urban) residents can access in a given radius?

For many counties in Kenya, to even have one of such a specialist practicing there would itself be a great privilege. It was said that there were only 20 oncologists in Kenya by early 2016.

In terms of cardiology sources indicated that by mid-2017, Kenya had 45 specialist cardiologists for 45 million total population yet there were 1435 cases on the waiting list while only 179 had benefited from open heart surgery and 252 from interventional procedures that year.

Many Kenyans continued to seek these services out of the country. According to cardiologist Dr Loyce Mutai, Kenya needed at least 5 specialist per referral hospital. Kenya relied on other countries to train its cardiology specialists. There was also the need to protect consumers from escalating costs of treatment. We could borrow some of the laws from other parts of the world which ensured to capping to achieve a realistic mark up in terms of how much one could charge to treat a certain condition.

The long wait

DK, 38 year old father of four sits in a pensive mood on bed number 20 in KNH surgical ward. Every morning he hopes the nurses will give him the good news that finally it was his surgery day. But not yet, as days go he was not sure when his life saving surgery was due because of an unpredictive waiting list that stretched upto the year 2018.

DK had been diagnosed with ischaemic heart disease 8 years after he had the first symptom. Previously, he had received treatment for many 'mis' diagnosis and spent over Ksh 300,000 Before someone recommended an echocardiogram that picked his condition. It was one year (and counting) since the diagnosis and now, it was one month since he was admitted to the ward awaiting open heart surgery. With every day of waiting, his second hand clothes business returns were waning.

[DK's story first appeared on April 5th 2016 in *Business Daily* as told by Stellar Murumba. It was not possible to ascertain if the surgery had been done by the date of publishing this book]

From 2014, NHIF rolled out the NHIF @50 Cardiac Care Indicator Project/Cardiac Surgery Partner Program consisting of participating hospitals, cardiologists' specialists, and cardiac surgeons to assist cardiac patients' access quality care. The surgical package of up to Ksh500,000 had eased the burden of specialised treatment. Though hardly enough in several cases, it was really something, a step in the right direction.

There was a lot of potential though with many examples. One that stood out in the recent past was an operation done at KNH on 1st November 2016 to separate Siamese twins Favour and Blessing who were born to a single unemployed woman aged 29 on 4th September 2014 conjoined at the sacral region. The operation lasted 24 hours and involved a team of about 50 specialists. It costed approximately Ksh 6m which was largely cleared by NHIF. See **section 4.9.2** of this book on Universal Health Cover.

The two healthy girls were discharged from hospital two and a half years later 15th June 2017. The successful operation reaffirmed the great strides Kenya had made in the health sector. Other strides included open heart surgery, organ transplant, andreconstructive surgery among others.

To increase client(s)' access to health care: *'...means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so'* (WHO, 2000). In Kenya households (usually out of pocket expenditures) remained the largest contributors of health funds.

Hospitals were generally financed through 4 main sources: 1) budget allocations from the national/county government 2) user fee revenues from users of hospital services 3) Reimbursement from the National Hospital Insurance Fund (NHIF), and 4) donations from non-governmental organizations and other charitable donors (See **Shot and left for dead** in Chapter 2 and **Now you have, Now you don't** in Chapter 6). In today's environment, consumer choice (power) is an important aspect of health care economics is a driving force in organizational survival (Ferketich, Phillips & Verran, 1990).

One report defined geographical access as up to one-hour walking distance, indicating that 50 percent of the population has access to public health facilities, 70 percent to private health facilities, and 80 percent to retail outlets (HERA 2005). However, this failed to indicate the significant disparities that existed between urban and rural settings and between various regions in the country.

It had been variously observed that there will be a tendency for more and more people to move to towns in the future. In the African context it was estimated that 800m people would move to cities in the next 10 years. This was both a challenge and an opportunity.

Access to health care does not guarantee good health because there are other factors such as social-economic status, genetic etc. But without such, access health is certain to suffer. Even with access each attempt to solve a problem like e.g. insurance in turn creates a new problem by stimulating a rapid rise in health care costs. Consider the following:

Forfeiting benefits to self for the common good

"We, Quebec doctors who believe in a strong public system, oppose the recent salary increases negotiated by our medical federations," The group said they were offended that they would receive raises when nurses and patients were struggling. Canada has a public health system which provides "universal coverage for medically necessary health care services provided on the basis of need, rather than the ability to pay."We believe that there is a way to redistribute the resources of the Quebec health system to promote the health of the population and meet the needs of patients without pushing workers to the end. The letter added, "We, Quebec doctors, are asking that the salary increases granted to physicians be canceled and that the resources of the system be better distributed for the good of the health care workers and to provide health services worthy to the people of Quebec". **Source:** CNBC News 6th March 2018. *https:// www.cnbc.com/2018/03/06/canadian-doctor-protest-their-own-pay-raises.html*

1.5 Service Delivery

Includes delivery of effective, safe, quality personal and non-personal health interventions to those that need them, *when and where needed*, with minimum waste of resources. It can also mean demand for care, service delivery models and integrated packages; leadership and management; infrastructure and logistics.



Pic: Service delivery (Courtesy of clip developer)

1.6 Crossing the Quality Chasm

The publishing of a report entitled *Crossing the Quality Chasm*; a New Health System for the 21st Century by the Institute of Medicine (IOM) was a big step towards describing access to quality care (IOM, 2001). The term "health care system" refers to the organization, financing, payment, and delivery of health care as described in greater detail in the IOM report.

The report defined a framework for the quality of a health care system, laid out six "STEEEP aims for improvement" (as outlined below) as a useful blueprint that could help guide decisions about what aspects of care to measure:-

Safe (S): The system should be safe (i.e., free from accidental injury) for all patients, in all processes, all the time. For example, there should not be lower standards of safety on public holidays, weekends or nights. Patients should only need to tell their health care providers information once, and health information should not be misplaced, lost or overlooked.

Timely (T): The system should deliver care in a timely manner (i.e. without having to wait on long queues that were wasteful and often anxiety-provoking). This domain addressed access issues. Long patient lines and busy clinics hinder individualized care and detailed documentation.

Effective (E): The system should provide care that was effective, based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcomes.

This domain concentrated on the appropriateness of care (i.e., care that was indicated, was as prescribed by protocols or was it given as per the clinical condition of the patient?) and addressed the problems of over use and underutilization of health care services.

Efficient (E): The system should be efficient (i.e., use resources to obtain the best value for the money spent). This IOM domain addresses the underlying variation in resource utilization in the health care system and the associated costs.

Equitable (E): The system should be equitable, meaning that care should be based on an individual client's needs, not on personal characteristics (such as gender, race, or insurance status) that are unrelated to the patient's condition or to the reason for seeking care. Health disparities are defined as differences in treatment provided to members of different racial or ethnic groups that are not justified by the underlying health conditions or treatment preferences of patients.

Patient-Centered(P): The system should be patient-centered. This concept encompasses the following: respect for patients' cultural values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support (i.e., relieving fear and anxiety); and involvement of family, significant others.

An ideal patient care environment ought to be able to measure all the six **"STEEEP** aims for improvement" IOM domains. The Kenya situation might only be able to measure a number of them with KQMH being adapted to provide some tools for doing so. For example the area of patient safety may be at its infancy in Kenya. There are now concerted efforts embracing quality management systems (ISO 9001:2008 etc.) certification by many health care institutions in the country.

Moi Teaching & Referral Hospital got ISO 9001:2008 and was the first public hospital to get the Quality Management Systems (QMS) certification status in 2009 and later ISO ISO13485:2003 on good manufacturing practices in its Intravenous Production Unit (IVPU) in 2012.A seminar on stakeholders on quality health care from Kenya and beyond in June 2013 recommended that KQMH be used as an accreditation standard for health care institutions in Kenya (Technical Report, 2013).

A further briefing on the IOM series of reports summarized ten rules for the delivery of care that were essential for a redesigned system (ACMHA, 2008). These included:

1. Care is based on continuous healing relationships.
2. Care is customized to patient needs and values.
3. The patient is the source of control.
4. Knowledge is shared and information flows freely.
5. Decision making is evidence-based.

6. Safety is a system responsibility. The fair and just *safety culture* of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behaviour that determine the organization's commitment to quality and patient safety (The Joint Accreditation Commission, 2015).

7. Transparency is necessary.

8. Needs are anticipated.

9. Waste is continuously decreased.

10. Cooperation among clinicians is a priority

For purposes of resource constrained setting this author would wish to add an 11th one - on reduction of abuse ('in all its form'…) as case sensitive for the Kenyan situation because patients who believe the provider is one who has their interests at heart, show greater satisfaction with the care received and are more likely to comply with treatment regimes. Some health care workers had reportedly exploited this goodwill and taken advantage of patients. Construct number 2 in Chapter 6 addresses some of these concerns.

Towards this end some attempts have been made by the Ministry of Health (MOH) to improve the quality of health care services. These include, among others: building more health facilities, providing more medications, recruiting more health workers and training health workers through education.

The Kenya Essential Package for Health (KEPH) outlined provision of comprehensive, integrated curative and preventive health services, available at the first point of contact, accessible to all (MOH, 2006). There are 5 age cohorts defined by KEPH and their major health needs these included:

Pregnancy to newborn (28 days) some of the issues were age of the mother, gestation, nutrition, screening for defects, ANC visits and checkups, individual birth plans, child birth, maternal/infant autopsy. Child upto 5 years (29 weeks to 59 weeks) monitoring health, growth and development, immunizations, deworming, treatment of minor illnesses, healthy diet, hygiene, childhood education, prevention of accidents.

Childhood to youth (5 years to 19 years) education on behaviour changes, lifestyles, STI's HIV/AIDS, laboratory diagnosis, medications, support groups. *Adult* (19 years to 65 years) monitoring of behaviour changes, encourage to be economically productive, modification of lifestyle for betterment of health, screening for disease, STIs/HIV/AIDS, lab tests, medications, preventive commodity.

Elderly (above 65 years) home based care, chronic illnesses, monitoring about health, screening for disease, curative services, treatment of old age diseases, rehabilitation, terminal illnesses, counselling, home visits, communication about death and dying.

1.7 Six Aims to Improve Healthcare

(i) Healthcare must be safe

This means that safety must be a property of the health care system and not based on individual provider's responsibility to somehow try extra hard to be more careful.

(ii)Healthcare must be effective

It should match science, with neither underuse nor overuse of the best available techniques for example every elderly heart patient who would benefit from beta-blockers should get them, and no child with a simple ear infection should get advanced antibiotics.

(iii)Healthcare should be patient centred

The patient's culture, social context, and specific needs deserve respect, and the patient should play an active role in making decisions about his/her own care. This becomes more and more important as more and more people require chronic rather than acute care.

(iv) Healthcare should be timely

Unintended waiting that does not provide information or time to heal is system defect. Prompt attention benefits both the patient and caregiver.

(v) The health care system should be efficient

Constantly seeking to reduce the waste and hence the cost of supplies, equipment, space, capital, ideas, time, and opportunities.

(vi) Health care should be equitable

Race, ethnicity, gender, and income should not prevent anyone in the world from receiving high-quality care. We need advances in health care delivery to match the advances in medical science so the benefits of that science may reach everyone equally.

What can be done?

We cannot hope to cross the chasm (IOM 2001) and achieve these aims until we make fundamental changes to the whole health care system. All levels require dramatic improvement from the patient's experience (the most important level) to the vast environment of policy, payment, regulation, accreditation, litigation, and professional training that ultimately shapes the behaviour, interests, and opportunities of healthcare.

A framework like Best Care Anywhere organizing Framework for Resource Constrained Settings (BCAOFR-CS) necessitates redesigning of the various functions, roles and responsibilities of the leaders in healthcare.

Changes in the landscape of health care, such as new technology, increased diversity in the workplace, greater accountability for practice, and a new spiritual focus on the mind and body connection require creativity, innovative leadership, and management models. Sound frameworks and models, along with evidence-based management practices, equip the leader with the tools to foster a culture of collaborative decision making and positive patient and staff outcomes.

Core competencies on that need to be impressed upon health care providers should include: Provide patient centred care; Work in interdisciplinary teams; Use evidence-

based practice; Apply quality improvement; Create a culture focused on improving safety; Utilize emerging technologies. Transformational leadership and evidence-based management are necessary for achieving them

1.8 Quality Health Equals Health Outcomes

Quality is equal to health outcomes (Porter, 2012, Porter-O'Grady & Malloch, 2015) as seen in the table below, some explicit health outcomes can be equated to quality health.

- Prevention of illness - Early detection - Right diagnosis - Right treatment to the right patient - Rapid cycle time of diagnosis and treatment - Treatment earlier in the causal chain of disease - Less invasive treatment methods	- Fewer complications - Fewer mistakes and repeats in treatment - Faster recovery - More complete recovery - Greater functionality and less need for long term care - Fewer recurrences, relapses, flare ups, or acute episodes - Reduced need for ER visits - Slower disease progression - Less care induced illness

Table:Quality is equal to health outcomes

Health care providers deal with human beings at their most vulnerable moment which requires of the providers a high level of personal involvement. If the aspirations of Kenyans concerning health are to be realized, healthcare providers and health care organizations need to work to ensure that the patients:

- Experience an improvement in their clinical condition, possibly including increased physical functioning, greater tolerance of activity, improved ambulation, and/or reduction of pain.

- Improve their ability for self-care, including performing wound care, taking medications on schedule, maintaining a nutritious diet, eliminating properly.

- Learn more about their condition and its treatment, including their own treatment regime, appropriate procedures, potential complications, what to do in emergency situations.

- Are aware of the elements of healthy lifestyle, including proper nutrition, weight management, activity, stress management, sleep, safety, infection prevention and control practices, disease screening. Acronym: Early Periodic Screening, Diagnosis, and Treatment programs (EPSDT). According to AMREF (2012), one approach to effective service delivery is by creating demand through: knowing

about health needs, increasing quality of care, improving on health literacy, increased medical insurance cover, and good behaviour and attitudes of health care workers.

D A clean environment, meals delivered on time at the right temperature and pleasant to eat, medication given when due (or when requested), comfortable space for the significant other where indicated- a clean healing environment for patients and their families.

According to Porter-O'Grady & Malloch (2015), the future of health care will depend on the ability of the clinical systems to interface well and work together across disciplines and the organization, to adjust to increasingly complex technology applications, to operate in a high–mobility accountable arena, ensure that the health needs of individuals are met and the health of our communities is advanced. It was possible to jump the queue in terms of technology in Africa. There were lots of possibilities of adopting and using technology to come up with innovative answers without creating the technology itself.

It matters a lot that our provider sensitive quality indicators meet and exceed our targeted goals, but it is also critical that we address issues that our clients perceive as quality indicators by our clients.

When the time comes we shall learn how not to leave anything to chance. Consider the following "Labelling of patients is nowhere in these standard operating procedures of patient admission. It means that it is not even part of your procedures to begin with," observed Ms Sabina Chege MP, who chaired the Parliamentary Committee for Health. Health workers at Kenyatta National Hospital missed basic but vital procedures before and during the operation, which resulted in brain surgery mix-up - one of the worst cases of medical malpractice. Reported in March 2018.

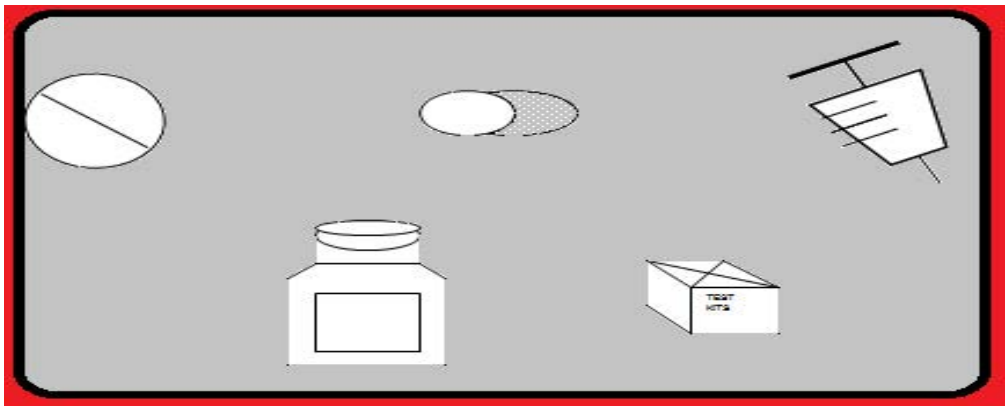


Fig: The aspirations of Kenyans have towards health care is the very ideal. 'Surviving on the available but often wrong treatment for whatever reason has no place in the future-now health system'. (Courtesy of clip developer)



Pic: 'How did I manage without it?' Kenyans generally rapidly embraced information communication technology, 9 out of 10 owned a mobile phone by mid-2018, and as it is they were-'looking out to the next best thing' in the area of ICT (Courtesy of clip developer)

1.9 Paying health care providers

Generally, the three most common approaches to paying health care provision were through: salary, fee-for-service and capitation. However each of these methods had its shortcomings.

1. **Salary**- Oftentimes there was no connection between payment and performance,

2. **Fee-for-service**: Payment is made for each service provided according to a set of official prices or tariffs, for example for an outpatient consultation, the cost of diagnostics, or a surgical intervention. This payment method created an incentive for providers and doctors to treat more patients and conduct more diagnostic procedures and clinical interventions. Potential problem**:** There was a risk that providers would over-treat patients in order to generate more income. This payment method may help to increase the delivery of priority services where coverage was very low, but there were also risks of escalating costs and providing an inefficient mix of services.

In fee-for-service, there is a link between the volume of services provided and the total payment, creating an incentive for providers to over-diagnose and over-treat, often referred to as supplier-induced demand (SID). Without necessary controls this could lead to cost escalation, the provision of unnecessary care, and greater inefficiency in the health system. This might partly answer why subscribers of medical benefits scheme have high rates of caesarean sections, as driven largely by the method of payment.

3. **Capitation**: Capitation funding is an approach to purchasing in which payments are based on the number of people registered with, or covered by, a particular health facility or provider. Payment based on the number of people being served, for example in a defined geographical area, or the number of people registered with a facility, irrespective of how much care is actually delivered/used.

A fixed amount per person forms the basis of the payment to the provider, although there may be adjustments to reflect varying health needs, most commonly the on age and sex profile of the covered population. Potential problem: There is a risk with

capitation payments that services will be under-provided, given that the provider's income is fixed; patients may be referred unnecessarily to hospitals or outpatient specialists by the PHC provider in order to minimise their expenses.

It was reported that NHIF was paying rebates of Ksh1000 per principal person (and dependants) who had registered to use it as a facility of choice per year to hospitals in 2015; many complained that this was quite a low figure. Some private facilities even pulled out of the scheme. There may be need to combine capitation with performance based indicators leaving the beneficiaries at a loss as to where else to go for health care.

3. **Mixed method:** results-based financing (RBF), links financial payments to providers based on the delivery of specific services, or targets met, that are expected to improve health. Other terms commonly used include performance-based financing, and pay-for-performance e.g. combining capitation payments with an additional performance-based payment.

4. **Diagnosis Related Groups (DRGs)** create case categories that are similar in terms of both clinical composition and the average cost of treatment. However DRGs, or similar payment systems which pay a fixed amount for the treatment of a particular condition, also face challenges. One of these is that patients may be discharged earlier than is clinically ideal; a second is that admissions may be "up coded" into a case group with a higher reimbursement rate. By paying per case, there remains an incentive for unnecessary admissions, especially for relatively uncomplicated cases.

As with all payment mechanisms, close monitoring and regulation is critical to counteract and limit the negative incentive of DRG e.g. combining DRG case payment with a budget cap to set an overall limit on funding.

5. **A passive purchaser** of services allocates funds irrespective of the service quality or the cost of delivery. Whereas a strategic purchaser allocates funds in a way which promotes improvements in service quality and efficiency. See **section 4.9.2** of this book on Universal Health Cover.

Summary

The characteristics of a responsive health system include: Speed and timeliness of delivery/Punctuality; Courtesy and helpfulness; Service reliability; Consistency in service delivery; Accuracy of paperwork; Positive attitude from staff; User-friendly systems/less bureaucracy.

Its functionality is evident through: Access to services; Quality of care and service delivery; Safety; Coverage; Equity; Efficiency; Effectiveness of health care delivery; Ethics, and rights-based approach in delivery of services; Sustainability of services. Changing the future will require that people look beyond their immediate self-interest to view the common good of a healthcare system that is accessible, affordable and of high quality.

A heightened level of public discourse will be needed, as the citizens is better informed and more actively engaged in shaping the future of the Kenya they want. They would want to connect this aspiration with their daily realities. They want the future now, or if it were possible to see how they could bring the future closer. The needed leadership, attitudes, actions and foresight of care providers will play a major role in determining the future of health care in Kenya. An epilogue at the end of this book ties up what has been covered.

The late Sir Winston Churchill, once British prime minister said that *the only way to predict the future is to create it*. Yes we can design the future from past successes but we can barely afford to bask on some past glory of some success stories because it is hardly part of the reality of health care in our setting, such stories are far between and amidst deprivation. The health care sector is made up of many different industries - from pahrmaceuticals and devices to health insurers and hospitals. Each with its unique dynamics. This book will try to touch each of them very lightly as to have some impact. Hopefully by sharing my recollections through the chapters in this book together we can create that future for ourselves and those to come.

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CHAPTER 2

The Outlook on Access to Quality Health Care in Kenya

Overview

Although it may be feasible to offer health services under a variety of conditions, there are certain infrastructure and health system components that are believed to be necessary for a consistent level of quality and appropriate utilization of health services. Indeed technically speaking feasible and cost-effective interventions exist, that have been tried elsewhere. This potential has not been fully realised due to the failure of health systems to improve the delivery and uptake of these priority interventions.

Apart from underfunding gaps exist in critical knowledge, evidence, tools, and capacity. To provide quality services, a facility must have the means to ensure that facility equipment and infrastructure are maintained in functioning condition.

Healthcare costs and attempts on mitigating these through some form of insurance represent an increasing percentage of gross domestic product for many countries, and it's growing. Over the last ten years, Kenya's budget rose exponentially (over four times) from Ksh 693 billion in 2007/08 to Ksh2.4 trillion in 2017/18. However allocation to health sector stood at Ksh 34.4b then and Ksh 54.9b in the ten years, by a mere Ksh 20b. For instance the National Treasury allocated Kshs 47.4 billion in the 2014/15 budget against the required Sh160 billion by the health sector. The trend for Kenya has been thereabout 5% of the national budget which fell short of 15% mandated by Abuja convention.

2.1 Beacon of Hope

Households, usually out of pocket expenditures remained the largest contributors of health funds, followed by the government, and then donors. The expenditure in Kenya was still skewed towards curative services and had continued to be skewed in favour of tertiary and secondary care facilities, which absorbed 70 percent of health expenditures. Nationally in 2015/16, the free maternity care alone would ideally cost the government an estimated Ksh 12.5b annually.

In 2015/16 for example, the health sector was allocated Kshs 59.26b to share between preventive/curative, 5.3b MTRH, 4.5b KNH, 4.3b free maternity. MTRH for example would be using Ksh650M to expand its facilities (Kshs 400M of which would go to the Cancer Centre). The Manu Chandaria Cancer Center in MTRH got commissioned in 2015. Then there was the Heart Centre, the children's hospital, Riley Mother and Baby Hospital as well as AMPATH centre were among the landmark expansions at MTRH. The hospital then was seeing 1000 patients per day (against a 1000 bed capacity), reconstructive surgery among others.

beds *Shoe4Africa Children's Hospital* which was part of MTRH opened on 12th August 2015 as the only dedicated public hospital for children in Kenya. Housing the first paediatric dialysis unit in Kenya.

Services at the children's' hospital included: outpatient department (OPD), 105 inpatient beds, Physiotherapy, Occupational Therapy, Operating theatre, ICU/HDU/NBU, X-ray, and Pharmacy among others. It is estimated that another referral hospital will be built within Eldoret at an estimated cost of Ksh 28b. The arrangement was that once the new facility is completed, the old referral would be handed over to the Uasin Gishu County government.

According to the head of policy, planning and health care financing at the Ministry of Health Dr. Peter Kimuui between 2013-2016 2.3 million women had benefitted from free maternity program at a cost of Ksh12billion. Namely: theatre, midwifery, medications, counselling, family planning among others. Hospital deliveries figures rose as follows:

No. of deliveries	Year
461,995	2012/13
627,487	2013/14
811,645	2014/15
911,959	2015/16

[Source: MOH Kenya]

The contribution of donor funding to the health system in resource limited settings can never be underestimated. In 2016/17 fiscal year Ksh 61b health budget, Ksh 28 b was donor dependent targeting projects as vaccines, HIV AIDS programs.

Other examples the Roll Back Malaria Partnership and the Affordable Medicines Facility-malaria (AMFm). The malaria program has had a positive effect on the availability, price, and market share of quality-assurance of artemisinin-based combination therapies (ACTs) in low income countries including Kenya. ACT had since become popular and synonymous with antimalarial treatment brand name among Kenyans.

ACT is the WHO recommended first-line treatment for uncomplicated *Plasmodium falciparum* malaria in all cases except the first trimester of pregnancy. Yet despite massive international efforts over the past decades, malaria continues to be one of the primary causes of mortality worldwide. An estimated 655,000 to 1.24 million people died of malaria in 2010, and more than half of those who died were children younger than five years. Of malaria deaths, 92% occurred in sub-Saharan Africa (Raifman *et al.,* 2014).

ACTs became more widely available and affordable. Widespread access to ACTs in both the private and the public sectors was crucial for averting death and disability from malaria. Even the prices of ACTs in private outlets were subsidized as a result. Generic malaria prevention message about Insecticide treated bed nets augments these efforts.

We know health care is not free, it not a typical consumer item, it is regarded as a basic human need by most people. Someone (somewhere, somehow) must pay, has paid or will be owing. Demand for health services is somehow involuntary and is often not consumer-driven. Spending money to implement lifestyle changes now to prevent a future disease doesn't make sense to some people – they can't see or feel the benefit of being healthy in the future, but they can feel the pain of giving up a favourite food now.

The need for and cost of health care services are unpredictable. Most people do not know if or when they might become ill or injured or what it is that they will be buying, nor be in a position to question how much it will cost. It could eat up all the person's personal savings, some people have been relegated to bankruptcy due to inability to pay medical bills.

Medical bills were unpredictable and difficult to factor into regular household spending. This means that out of pocket is more flawed mode of paying for health services, worse still because it overburdens those with little disposable income, in turn becoming poorer and less healthy.

If and when people spent more money on healthcare they had less to spend on other goods and services. It was not rare for a number of Kenyans to find themselves in perilous circumstances that involved draining every available insurance and harambee cent in the moment of greatest vulnerability, as bills kept piling.

The opposite was also true - as the consumer index (changes in basket prices of consumption goods and services) was affected, one of the basic needs that remained unmet was access to quality health care. The unfortunate thing was that even then, many were putting their money into a bad health system.

In a study by Kruk and colleagues (2009) did The World Health Survey (WHS) entitled *Borrowing and selling to pay for health care in low- and middle-income countries.* On average, 25.9 percent of households borrowed money or sold items to pay for health care. They borrowed money from family, friends, or money - lenders including *shylocks* or to selling their assets. Families may still owe accrued medical debt when they took on new debt.

The risk was higher among the poorest households and in countries with less health insurance. Health systems in developing countries had failed to protect families from the financial risks of seeking health care.

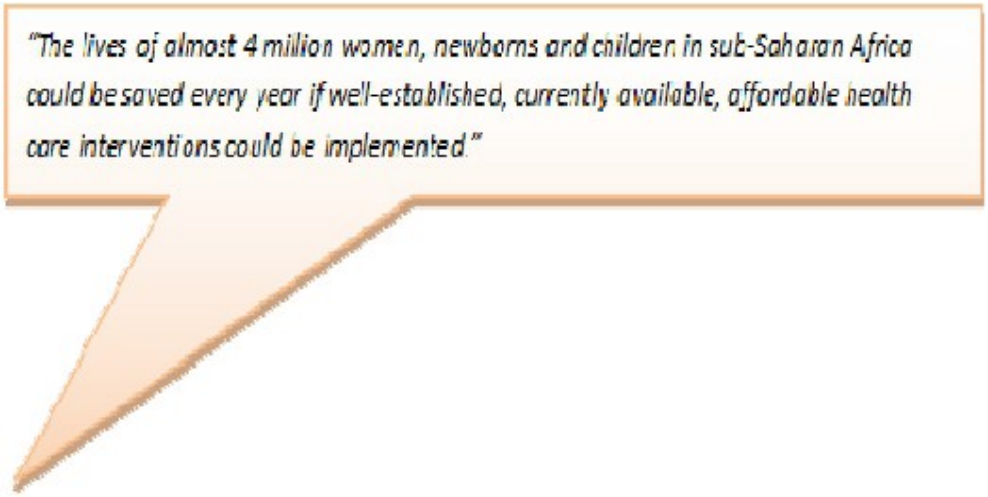
It was dangerous to presume that consumers could evaluate the costs and benefits of spending their own funds on healthcare unlike the insured who are shielded from most of the cost implications of their decisions or their health care providers' - at the point of service. (See **Shot and left** for dead in Chapter 2).

According to 1987 National Medical Care Expenditure Survey, out of pocket payments took 12% of the income of families in the nations'(US) lowest income quintile and hardly 1.2% for the families of wealthiest (5% of the population) (Bodenheimer and Sullivan,1997). This is aggravated by the fact that in general lower income people tend to be sicker thus requiring more out of pocket than the wealthier and healthier.

According to Kruk *et al*., (2009) out-of-pocket payments accounted for 70 percent of health financing in low-income countries, compared to 14.9 percent in high-income countries. This was consistent with the low availability of prepayment (that is, tax-based social health insurance or voluntary insurance) in low-income countries.

The Jubilee government started the *Inua Jamii* cash transfer fund, a form of hardship financing, on a monthly basis and lift up the lives of the vulnerable (orphans and other vulnerable children', those with severe disabilities', vulnerable elders aged more than 70 years and the urban poor. For some unknown reason inmates were left out).

It was reported that a total of Kshs 17.4B had been transferred in the first 900 days (By June 2016) of Jubilee administration. It would be only fair that the amount should reflect changes in the cost of living. In this book we shall attempt to look at health insurance from various perspectives.



Quoted Joy Lawn, Director of Maternal Reproductive and Child Health, London School of Hygiene and Tropical Medicine.

2.2 What is The Outlook?

Kenya is the world's 47th largest country with an area of 582,646 km^2. The Kenya National Bureau of Statistics (KNBS) placed its population at 38.6 million people (results of 2009 census, done 10 yearly) with approximately 6 to 8 million living in the urban areas. It was estimated that by 2030, 65% of Kenya's population will be living in urban areas. The population growth rate had remained high (2.4 to 3% annual growth rate).

The population was diverse, comprising 44 ethnic groups. 42% of the population was under 15 years while 28% was aged between 15 and 35 years. Only 30% were over 35 years, making Kenya a youthful population median age of 18 made it to have the youngest age world over but comparable to the African context where 61% of the population was under 21 years.

The health care system in Kenya is structured in a step-wise manner so that complicated cases are referred to a higher level: dispensaries, health centres district hospitals, County Referral hospitals, and National referral hospitals. Gaps in the system are filled faith run units, private for profit (PFP) and private not-for-profit (PNFP).

The public health facilities are mandated to provide services to all people without discrimination at affordable or no charge for emergency. Kenya had a total of 9,905 health facilities in as at 26th Dec 2014 2014, of which approximately 75% were dispensaries and 12% health centres. Hospital level institutions made up the rest at 13% (see **Shot and left for dead** below).

People living in rural and remote areas struggle to access timely, quality specialty medical care. According to the World Health Organisation (WHO), Kenya is one of 57 countries with a critical shortage of healthcare workers. Residents of these areas often have substandard access to specialty healthcare primarily because specialist physicians are usually located in urban areas, reaching only 15-20% of the population (i.e. 80% of clinicians' serves 20% of the population).

Therefore Kenya's skewed healthcare infrastructure suffers from urban-rural and regional imbalances, lack of investment, and a personnel shortage (Ministry of Medical Services, Kenya, 2011). Kenya Health Sector Strategic Plan (KHSSP III *July 2014–June 2018*) defines health infrastructure as any investment in physical infrastructure, medical equipment, information and communication technology, or select transport.

2.3 Late and Gloomy – the Cancer Situation in Kenya

Cancer had become a serious disease and killer in Kenya. Up to now, it was not very clear how to detect this disease in patients early enough in most cases. As a result, a lot of the time, the disease was detected late, which led to deaths. At least we can prevent and detect early, what would it take? This is the million dollar question. It was unfortunate that The National Cancer Institute had remained on only on paper with only one staff (housed in Ministry of Health Headqaurters), no office of its own and no budget five years since it was established in 2014.

Cancer research could request for data in an effort to run various types of tests and also combine it with population and health survey data in an effort to propose measures to take in order to detect cancer early. But there were issues of privacy, confidentiality and consent of the respondents before they participated in such studies.

In terms of data management it was also important to establish whether the data could be shared or not. About 78% of Kenyans live in rural areas, which means that many patients requiring care may travel up to 600 km (to Nairobi) access cancer services.

The waiting time for treatment at Kenyatta National Hospital was extremely long, and this is a problem, and therefore there is a narrow window of opportunity to treat cancer effectively. The option of private cancer treatment and after-care was not actually an option for the majority of Kenyans, as treatment costs in these hospitals were so astronomical that many patients' families marshaled the resources they could to enable the patent travel to India for cancer treatment instead. More effort and resources are needed to make treatment more widely available and accessible (*Tackling Cancer in Kenya* PLoS Blog by Dr. Matheka D. posted on January 15, 2014).

Sources indicated that there are about 39,000 new cases of cancer diagnosed annually in Kenya; the leading ones being cancer of the breast & cancer of the cervix among women and cancer of the prostate and cancer of the throat among men.

A program cancer week cerebrated in the month of February theme: 'Free Cancer Screening Nationwide: The Best Protection is Early Detection' was a great move with the media running cancer awareness series like *kadhia ya saratani*' on Kenya Television Network and Cancer Awareness Centre of Kenya.

Early detection can only be successful if and when it is linked with effective treatment. For example early detection of cancer of cervix is based on the observation that treatment was more effective when the disease is detected early as there are greater chances that curative treatment will be successful. 30% of treatable cancers (colon, breast, rectum, larynx, skin, cervix, mouth) can be cured if detected early.

According to a study completed by the Institute of Economic Affairs reported that over

39 Kenyans died every day from cancer in 2014, up from 33 deaths in 2010. In 2014, it was reported that one in 14 deaths was caused by cancer. 60% of fatalities occurring among people who are in the most productive years of their life. We commend efforts by *Gundua Foundation Kenya*, *Kenya Cancer Association* (KenCASA) among others. https://www.facebook.com/Gundua-Foundation-Kenya-1073615956014948/?fref=nf

Cancer of cervix (ca cx) was caused by human papilloma virus (HPV). Five out of six women with cervical cancer lived in developing countries, which possess only 5% of the global resources for cancer control. It was the most common women's malignancy in Kenya and many other locations in sub-Saharan Africa.

The ca cx was the 2nd most common cancer and the 5th most deadly cancer. It was 5 times more prevalent in East Africa than in UK. Due to pap testing, cervical cancer is rare in Canada or the US; however, it is the number one cause of cancer deaths in Kenyan women.
These were huge disparities in detection, prevention and patient outcomes between low-income countries and high-income countries. In 2006, 2354 women in Kenya were diagnosed with cancer of cervix yet less than 7% of these patients got optimum treatment to eradicate the disease. It had been classified as an AIDS-defining illness in women with HIV infection (Maranga, Gamal, A., Gichangi, P., *et al.,* (2013).

Unique circumstances surrounding access to quality health care in resource constrained settings were explained by Maranga, *et al.,* (2013). This team studied factors contributing to the low survival of cervical cancer patients undergoing radiotherapy in Kenya. They followed up 355 women diagnosed with cancer of the cervix (ca cx) at the department of gynaecology and departments of radiotherapy at Kenyatta National Hospital between 2008 and 2010.

Of 80.5% of patients had presented with advanced stage disease (stage II and above) only 6.7% of patients were received optimal treatment. As many as 42 percent (146 women) of these patients were untraceable during the period of the study. Meaning that this group did not receive treatment. Of the remaining 18% (64 women) died during the study period (2008-2010):

> 'Our figures predict that less than 20% of those left will survive during the next two years. Lack of awareness, late stage at which women get diagnosed, in accurate assessments of the extent of disease and long waiting time for treatment as well as fatalistic attitude were all significant factors, which could make a huge difference in survival rate[8].
> Other concerns included poor follow-up, lack of trained personnel, unaffordable treatments in combination with socio-economic and cultural factors which all operate within an ill-structured health-care system'.

Even for ca cx stage 1 the outcomes were not good either. What are the barriers to providing full treatment? The main obstacle is that patients have to pay and simply cannot afford it. Even where cancer is incurable it should be possible to slow its progression, prolong lifespan, and relieve any symptoms such as pain, per vaginal bleeding through palliative care.

Kenyatta National Hospital and Moi Teaching and Referral Hospital were the only public hospitals capable of handling cancer problems. Currently it took a patient 2 to 3 years for patients to access radiotherapy treatment at KNH in what was christened *patient plus patience*. The waiting list usually had over 1000 patients at any one time. KNH had only 3 machines.

2.4 Maternal & Child Health

In June 2011, the United Nations Population Fund released a report on 'The State of the World's Midwifery'. It contained data on the midwifery workforce and policies relating to new-born and maternal mortality for 58 countries. It stated among others that in 2010 maternal mortality rate per 100,000 births for Kenya was 530. (When compared with 413.4 per 100,000 in 2008, and 452.3 per 100,000 in 1990, then the trend is worrying).

Reduction of child mortality and MDG Goal number 5 – improve maternal death.
The under 5's mortality rate, per 1,000 births was 86 and the neonatal mortality (as a percentage of under 5's mortality) was 33. The aim of this report was to highlight ways in which the Millennium Development Goals (MDG) could be achieved, particularly Goal number 4

In Kenya the actual number of midwives per 1,000 live births data was unavailable then but an estimated lifetime risk of death of 1 in 38 for pregnant women was unacceptable (UNFP, 2011). Infact The Safe Motherhood Interagency Group (which includes: UNICEF, UNFPA, the World Bank, WHO, International Planned Parenthood Federation, the Population Council and Family Care International) have recognized maternal death as an issue of social justice. (See Appendix XII)

Kenya had made several strides towards the realization of quality health care, perhaps not as good as it ought to but nevertheless some progress has been realized. The Office of the First Lady created the *Beyond Zero Foundation* to help mothers and children survive and thrive.

It was hoped that 'Beyond Zero Campaign' would catalyse government, individuals, health, private and international organizations efforts to reduce Kenya's high rates of maternal and child mortality. The immediate goal was to equip all 47 counties with mobile clinics, so that health services are brought to within 5 miles or closer to those who needed them. Beyond Zero is a call to: zero new infections; zero discrimination; zero deaths among others.



Pic: Leadership from the top. Kenya's 1st Lady H.E. Margaret Kenyatta. Her commitment in mobilizing support across all stakeholders including Maternal Neonatal Reproductive Health (MNRH) 'beyond zero campaign' and networks of people living with HIV/AIDS (PLWHA)

(Picture used with permission)

It also aimed at accelerating the implementation of the national plan towards the elimination of new HIV infections among children. This Campaign launched on the World AIDS Day, 2013 was part of the initiatives outlined in the 'Strategic Framework for the engagement of the First Lady in HIV control and promotion of maternal, new born and child health in Kenya'. The framework aimed to galvanize high-level leadership in ending new HIV infections among children and reducing HIV related deaths among women and children in Kenya.

On 9th March, 2014 the First Lady Half Marathon took place Nairobi. Later, on 13th April 2014, with the health of mothers and babies on her mind, she ran the London Marathon for over seven hours to show her commitment to this cause. On 4th July 2014 she launched the first fully kitted 'Beyond Zero' mobile clinic, which was sent to Taita Taveta County.

Taita Taveta County was among the counties with the highest maternal deaths in the country, standing at 600 deaths per 100,000 live births. The national maternal mortality rate then was 488 deaths per 100,000 live births according to official government statistics while 5,500 women in Kenya died every year due to pregnancy related complications and 108,000 children did not live to see their 5th birthday, while 13000 children got infected with HIV.

It was expected that the mobile clinic would make a big difference to the county's residents many of whom are sparsely spread and have difficulties accessing medical

facilities (Beyond Zero, 2014). The campaign by 5th December 2014 donated the 15th and 16th mobile clinic to Kilifi and Kwale counties (31 more to go).

By March 8th 2015, the date of the 2nd 1st Lady Marathon at Nyayo stadium, 21 mobile clinics had been realized. Under the World Bank sponsorship - Beyond Zero Campaign initiative, in April 2017 admitted 400 students to KMTC's for Kenya Enrolled Community Health Nursing (KECHN).

On 9th September 2017 the 47th mobile clinic was delivered for Nairobi County bringing in to an end one phase of the program. The next phase would involve building a state of the art national referral hospital for mothers and children. 4 years later, on June 11th 2017, Beyond Zero held celebrations at Kasarani Sports Complex to reflect on achievements and missed opportunities. Some of these included reduction of HIV in children by 50%, reduction of maternal mortality from almost 6000 to 4000, improved maternal health and child survival.

With 32 Beyond Zero clinics, 47 mobile clinic, the facilities had served 30,000 Kenyans by then. It was notable that it was during the last 4 years that some counties managed to perform their first caesarean section since independence in effect saving the lives of many mothers. These included Lamu, Marsabit and Mandera.

Apart from the upcoming national referral hospital, the next forward-looking phase aimed at among others elimination to beyond zero mother to child transmission of HIV and syphilis. By 2017 the incidences mother to child transmission of HIV had reduced from 27,000 in 2013 to 7,000 (*Jubilee manifesto*, June 2017).

The 1st Lady had managed to mobilize support from: philanthropist, corporate sponsors, volunteers, runners among others into a commitment, sacrifice, generosity for a stronger, healthier and resilient future of the mother and child in Kenya. It was recognized as a unique health model that exemplifies leadership in health.

Her efforts were recognized as *'UN Person of the Year 2014 Award'* for raising awareness of the plight of women and children; and *'OLX Soma Award'* for best use of social media for charity. In 2017, she also became honoured *Fellow of Honoris Cusa* award by the Association of Health Professional and the Royal College of Obstetricians and Gynaecologists (RCOG) in Cape Town.

2.4.1When all is said and done

Just like many other great ventures, Beyond Zero might face certain challenges from the observation of some actors in the health sector. While the mobile unit is donated amidst pomp, songs, speeches and editorial applause, that's about it. Once the aura had died, it was

handed over to the County Director of Reproductive Health but with no budget, staff (except the driver), and technical knowhow to run it. It would have been good to develop a policy for this one, it is worth the effort.

New trucks have reportedly remained packed at base for weeks on end. Sooner than later it will rarely go for outreach because there is no fuel for the truck and the generator. Since it is not an ambulance it requires that an ambulance backup accompany it. What about support for staff who have to work long hours only to be dropped in town late, to make it home on their own? It would not be rational to expect the same staff to turn up every day for the outreach that will last one week. Volunteers (if at all) and acts of altruism sooner or later run out of steam.

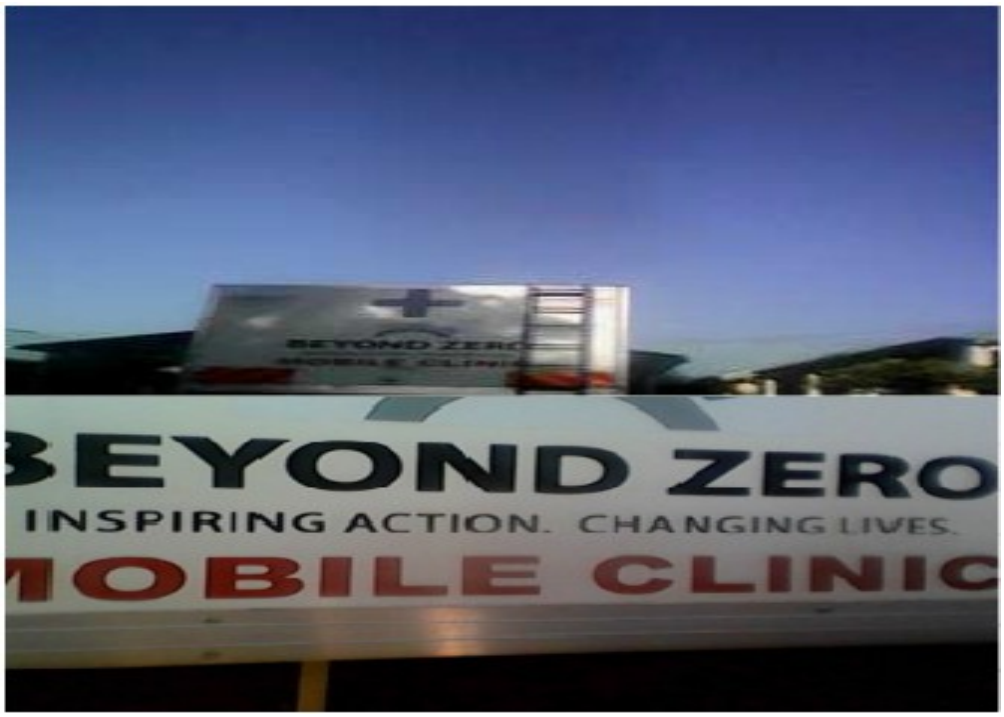
One would be tempted to dismiss them as teething problems or as petty issues but how differently can we run the Beyond Zero unit? Optimism and reality are two things one needs to be careful not to confuse in any case. Once the fanfare has died what will sustain this initiative? The old ways that characterized many projects of plunder, vandalism, waste and abuse will just not work.

The lifecycle of many projects have been almost predictable to say the least… One day it's a missing this, the next day that other gadget does not work, the donor pulls out, or worse still where systems don't exist (and you can be sure they don't in many parts of sub-Saharan Africa) - the goodwill was nolonger there especially from the political class.

Progressive (unparalleled) depreciation is common knowledge concerning government vehicles, a good number of them stall for prolonged periods due to simple mechanical/electrical faults. A great number of users also do not get proper orientation, lack due conscientiousness or are not patient enough to learn on how certain gadgets work.

Concerning machinery and equipment, some staff would fiddle & fidget with the gadgets, even cause to malfunction even before they get to be used. Though it does not occur in all cases, many a public officers were not keen on inventory keeping or planned preventive maintenance, what can disappear would likely go missing too.

A long serving driver admitted to a common challenge across a number of government and parastatal (read 'health sector affiliated') vehicles: that of failure to top up the lead battery with its regular dose of deionized water so that some of them often would be running on *dry cells* and failed to start-crank effectively.



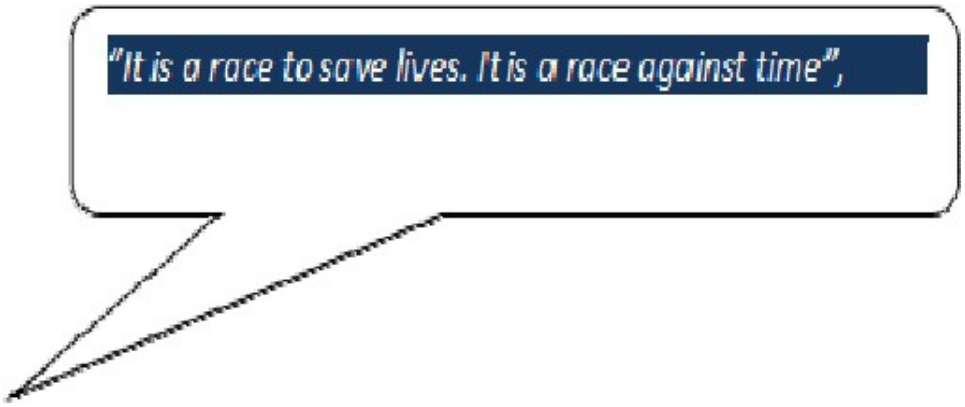
Pic. A Beyond Zero truck packed on site
(Photo courtesy of SM Kamau)

It was not hard to imagine how many run on less than the minimum level of lubricating oil. There was an ever present chance that an unscrupulous dealers (either with or not in cohort with those concerned) will sell a worn out used part as a spare part. All this because it's *hii ni mali ya umma* Swahili for *this is public property*.

Quite often inventory keeping had not been taken seriously in public health facilities. In one instance both the original and the unit copy were under the custody of the same officer. Entries lacked one or more key features – issue date, serial numbers, location, withdrawal date, disposal, signature, name or date existed in the records. Some unit in- charges apparently had no idea of the what/whereabouts of the inventory.

Allocating resources with little influence and oversight over how they are going to be utilized has let down many noble programs in the past. It was notable that invaluable equipment disappear somehow, not a few of such cases happened after the equipment was taken for servicing.

Like all such ventures Beyond Zero required optimism. It was not about the First Lady, it is about the gift she had bequeathed Kenyans. Even small ventures can affect so many lives in a great way. Beyond Zero Campaign Initiative is by no means small. It can achieve so much if well managed. The First Lady underlined the urgency to ensure all mothers and children access critical healthcare saying facts and statistics of the senseless deaths that continue to occur are staggering and sad.



In the words of Her Excellency The First Lady Margaret Kenyatta

Speaking at the JW Marriott Scottsdale Camelback Resort in March 2016 when she attended a First Lady's fund-raising luncheon attended by over 1500 supporters and sponsors, mainly the business community from Arizona, USA. The initiative had received commitment for support from Belinda Gates wife of Microsoft founder Bill Gates and musician Madonna among other celebrities.

Just like the free maternity care it is good to guard against excessive optimism by figuring out a hypothetical scenario e.g. As time passes, and budgetary resources and political support that were once available slip away under the impact of electoral change and shifts in the economy. We have seen in the past some *flagship* initiatives become consolidated with another program, then taken over by a different bureaucratic unit, and eventually disappeared. The biggest casualty so far had been the free maternity one of flagship projects of the Jubilee administration. Consider the following:

-In 2015, the Ministry of Health imported fully kitted 100 mobile clinics from China at Ksh800m. A news reporter described 99 of them as 'stacked, fully equipped and immobile' since they had been lying idle for more than 3 years (by mid- 2018) at the National Youth Service camp Miritini, Mombasa. Awaiting deployment to various counties with apparently no clear timeline from the Ministry of Health.
Each container spotted a pharmacy, a toilet, a consultation room to offer maternal child health, growth monitoring, immunizations, family planning, HIV care, emergency care, post-rape care, tuberculosis care, laboratory among other outpatient services. The same question –why were they still there at the NYS Camp? The Auditor General's report in early 2018 admonishished the Ministry of Health for paying for the procurement of the portable clinics before they were installed, commissioned and handed over, a flagrant violation of the the contractual agreement.

When would these critical life giving clinics reach those most in need - the hard to reach and slums in urban areas? Kenyans had not gotten value for money since another year later (mid 2017) they were still in the yard as they were under investigation. Parliament had cancelled the remaining part of the Ksh 1b funding to the program.

Perhaps it would have been better to release them as investigations continue and before the consumables expired. Pastoralists' communities for example needed the mobile clinics that not only converged with their lifestyle but also met their curative and primary health needs. But then, these were not the only cases under investigations, it was almost 10 years since investigations involving Clinix and Meridian clinics commenced.

Just before we let go of Beyond Zero – one last word

It was expected that Beyond Zero's sustainability would be through the Government of Kenya (Ministry of Health) and the County Governments. Why so? They would be expected to reciprocate since they were the recipients of this advocacy project anyway. At the same time health care professionals' concerns as implementers of the project needed to be addressed since as we have seen above they were quite consequential.

The project was hampered in a big way by crisis facing human resources for health that bedeviled the health sector due to perennial industrial actions since 2013. It was cited that this was one of the critical reasons that led to Beyond Zero suspending its activities temporarily at the end of 2016. Hopefully it would relaunch soon although 2017 was by large more hit by the strikes. Doctors alone did a 100 days, while nurses' strike went on for five months, with other cadres joining in at the tail end of the nurses' 4th month or some other point. During a comeback, Beyond Zero launched its strategic framework for 2018-2022 on 8th March 2018.

In the opinion of this author (and may be a few others) it was unfortunate that Beyond Zero much as it was well conceived was not always well executed. The energy, the impetus and force to continue pushing for better maternal neonatal child health care depended to a large extent on raising awareness and funds but moreso how these would be spent.

Just before we let go here comes The Heshima project

Heshima is a Kiswahili word meaning respect, honor, dignity, discreet, polished, noble etc. This was a collaborative initiative spearheaded by Population Council, Ministry of Health, USAID, Federation of Women Lawyers of Kenya (FIDA), National Nurses' Association of Kenya - NNAK (midwifery Chapter) among others [www.Popcouncilorg/.../heshima]. It clarion call *Promoting dignified and respectful care during childbirth*. It aimed to investigate endemic abuse of delivering women by health care providers and develop interventions. Practices which violated a woman's human rights and may discourage her from having an attended delivery in a health facility. In effect a major reason for choosing to deliver at home.

In its preamble page, it observed that disrespectful and abusive care during childbirth which included: medical procedures performed without women's consent, discrimination, nonconfidential care, abandonment or denial of care, detention, physical and verbal abuse.

In the preliminary reports, 1 in 5 women in Kenya had been humiliated, abused, hit or asked to bribe in their most recent birth. Nine out of 10 health workers reported to have heard or witnessed colleague treating women inhumanely. Some women in Magadi, Kajiado County alleged pinching with scissors 'to hasten delivery'. Health workers owned up that some of their colleagues mistreated the sick. In a 3-day forum dubbed *Kenya Health Forum 2018* in March 2018 at Laico Regency Hotel Nairobi, discussed among others the impact of negative attitudes by staff. There was need to train on customer care and attitude.

Apart from various articles published (Warren C, Ndwiga C., et al 2017) from the study media reports seemed to erupt with these sort of news on an almost regular basis, the #KNHrot perhaps being the chief of them all. Initial investigations into sexual harassment of post natal mothers on their way to newborn unit at night was neither substantiated nor refuted since the whistle blowers and victims did not come forward.

Recognizing other individual efforts

To take the Beyond Zero story a step further let us look at another advocacy project that was done may be not on a large scale but which if it had continued to see the light of day would have made a lot of difference. May be Beyond Zero would have been anchored onits successes. Anyone remembers the Ksh25 million mobile clinic for Rarieda constituency in then Nyanza province that was initiated by a former legislator?

It was launched by the (then) President of Kenya H.E. Mwai Kibaki on 9th August, 2005. There was nothing like it in Kenya. It stifled chiefly because of the Member of Parliament lost in the following elections. At some point in 2011 the residents wanted to set it ablaze for political reasons despite the fact that it had turned Rarieda into a model constituency for the rest of the country.

Otherwise, how does one begin to explain Hon. Raphael Tuju's of Rarieda constituency's predicaments or even Hon. Peter Kenneth's of Gatanga constituency? They both had impeccable development records in health care among other things. Maybe the less we say of politics here the better.



Pic: Midwife in a rural health facility (Picture courtesy of UNFP: TheStateofTheWorld'sMidwifery")

Women in remote villages have to give birth alone and aid themselves or have the TBA assist them. Although this is an example of harmful behaviours the routine acceptance of it is largely benign. It is hard to antagonize the TBA that a heavy sneeze from inhaling a pinch of snuff works wonders *to do that last final push* to hasten 3rd stage delivery of the

placenta. When the TBA insists that she only cuts the cord upon delivery of the placenta what evidence do you as a midwife have that would convince her of the dangers of such a delay?

Poverty issues - when they come to hospital but and they cannot afford the services. Here is a quote by a service provider in the antenatal clinic:

"...So if you tell this client that to go to [another facility] and she knows she needs fare to go...she opts not going. So instead of coming back to you because you have already written ultrasound and she has not gone she decides now to go and sit at home and even at delivery she doesn't want to come back here because she knows she has not done as the doctor instructed..." (Respondent, sub-county hospital in the rss-baseline–assessment.pdf report (2013)

To address the gaps in access and increase uptake of skilled attendant during delivery in some poorly serviced counties 'mothers home' have provided some relieve. This is maternal shelter or a room within or close to a health facility that accommodates pregnant women who are closer to their estimated delivery date (EDD) but live far away from the facility. The women come to the shelter days before they are to give birth and enjoy close supervision by health personnel as they wait to deliver (about 60% of deliveries in Kenya took place outside the hospital without a skilled birth attendant).

The shelters are meant to address the issue of distance which has been cited as a key reason why women, particularly in rural areas, prefer to give birth at home and not in hospital under skilled care to a 'half-way home to hospital'. "Such shelters reduce the distance for women as well as increase the uptake for skilled birth care," said Dr. Nicholas Muraguri (then Director of Global Plan Secretariat), during a meeting organized by World vision whose theme was Strong Women Strong Kenya. Save the mother initiative a partnership project of AMREF and Chase Foundation (Chase Bank) sought to train 1500 midwives by 2015 to help reduce maternal mortality. Dr. Muraguri would later serve respectively as Director of Medical Services, Principal Secretary, Ministry of Health.

To remain relevant, to continue attracting clients the initiatives must be able to convince the community of their utility value. Make a decisive difference even if it means saving a small number of women or neonates who would have otherwise died, something that the TBAs were incapable of doing.

World Vision International has set up a maternal shelter at Sagala Health Centre in Taita Taveta County, in the coastal region, and fully equipped it with beds and basic amenities. The shelter has a capacity of six women at any given time, and they reside there with close relatives while they wait for their delivery period (World Vision, 2014).

In an ongoing study that this author undertook on 'Chama cha Wazee'- male champions in Maternal Neonatal Child Health (MNCH) from Meteitei, a very hilly region of the Nandi escarpment (several parts were inaccessible by road) would benefit from a maternal shelter. They have since written to the Governor through the County Chief officer of Health with the proposal (Kamau *et al.,* 2015, Kamau *et al.,* 2017).

This would end the *'woiye'* stories of a mother dying in some remote village uphill as

people struggle to get her down to hospital on some rickety wheel barrow or sackstretcher, an innovation conceived out of necessity. It was scaring for some that some of those women who left the rugged mountainous villages (most after hours of tears, sweat, and blood in the hands of a TBA) on a 'stretcher' never came back.

Chama membership was more of a relationship of informal social protection. Chama was one of the mainstay of social economic protection in case of a catastrophe (see below) in many Kenyan neighbourhoods.

In the rural areas and slums especially neighbours were often the only safety nets. They shared a borrowed necessity, formed neighbourhood protection 'vigilantes', lately community policing *Nyumba Kumi* intiatives. In the words of Keneddy Odede, 'Our neighbours watch over our children in our absence, our neighbours are necessary for our survival in our lives and struggles'.

'We laugh together, we borrow from one another… our survival is interlinked… knowing that tomorrow is a new day to build together'. [*Daily Nation* p.15 August 3, 2017. *Opinion*: Real winners and losers in election chaos, by K. Odede, he is the co-author of New York Times best selling *Find me unafraid: Love, loss and hope in an African slum*] **(**Please see **Shot and left for dead** in chapter below).

For example *Community Strategy Wheelbarrow* inscribed in red and in capital letters, equipped with a siren and a mattress was an accepted norm in the slums like Kibera where most narrow backstreets were inaccessible by other means. In the backdrop of these unique circumstances one almost is tempted to ask still, would it be better to buy tens of ambulances for the county or ensure adequately equipped hospitals? For some maybe the ambulance is better, but for countless counties it is reaching the patient where they are and manage them there (thanks to the mobile clinic, Beyond Zero etc.).

Ahadi Kenya Trust an NGO in partnership with Lotto Foundation (a subsidiary of Lotto, a betting company) came up with an innovative called *Ambulance Mashinani* = 'village' ambulance.The motorcycle pulled carriage as equipped with medical supplies, 1st Aid and delivery kit. It had a vast utility value: took the disabled, poor and immobile persons for medical appointments, check-ups and treatment; emergency and rescue operations; accessed hard to reach areas with poor road networks (villages and slums); service to jigger victims; discharge home transport for recovered or readmitted patients. It also had a portable ultrasound scanner for assessing pregnant women wherever they were.

Shot and left for dead

The door to my sitting room was slightly ajar and, from nowhere a young man dressed casually edged in and said "we have come". Before I could register what was happening a shot fired and I was hit in the stomach. I realised I had been shot but felt no pain. Three other men entered and started asking for money menacingly…

It was then I noticed I was bleeding quite heavily, blood had started to flow onto the floor…Although I was mostly incoherent and feeling very cold, I managed to tell them (the neighbours

who came) I urgently needed to get to hospital. My brother ran to his house and came back with Ksh1000 ($10). A neighbour in a company vehicle offered to take me to hospital. Up to 10 people piled into the back of the pickup and sat opposite ends with interlocked hands I was laid on the manmade stretcher. As we drove off someone called the nearby police post to report the incident.

We arrived at a hospital in Buruburu Estate, and my brother spent Ksh500 to open a hospital card for me. He was then asked to pay a deposit of Kshs 20,000 before they could admit me. He didn't have that money on him but when he asked them to admit me and he promised to bring the money the next day, they refused. He pleaded with them but they were adamant. I felt very helpless and despaired at the thought that to these people, my life was not worth saving simply because we didn't have money there and then. But then they offered an alternative –they would give me an ambulance to take me to another hospital. The only snag was we had to pay Sh1,500 for it. We did not have.

We were stranded at the reception. The Police came and one of them whom I came to learn was a police reservist offered to pay the ambulance charges, I have never been so thankful… Finally to the next hospital reception, asked for a deposit, off course we did not have. The staff sympathised with our predicament and I was wheeled to the operating theatre.

Fast forward: That same day Nzioka took a loan of Ksh20,000 from his cooperative, then a cousin came and deposited Sh10,000. Ten days later accumulated a bill of Sh288,000. I asked my doctor if I could be transferred to Kenyatta National Hospital to cut down on the bill but he said I was due for discharge any day…

I welcomed this news because it meant I could participate in raising funds to clear the bill. My workmates relatives and friends had managed to raise Sh220,000 and my brother's workmates had raised a further Sh38,000. There was still a balance of Sh30,000 to be paid which meant I could not be discharged just yet. As if Nzioka had not done enough he deposited the logbook of his car as security so that I could be allowed home'.

[Storyline: *One minute, H.O.was face to face with ruthless gangsters, the next he was being overwhelmed by the selfless acts of those around him*. Appeared in *My story*, as told to Steve Biko Oyugi in *Daily Nation*; Wednesday, September 7, 2005].

A *Chama* (Swahili for group or committee) is made up of members who share a common interest such as friendship, location, business or employment etc. Typically the group's activity involved pooling individual savings of members as a foundation for building capital. Members were encouraged to save with the group. Group savings was then handed to one or more members each month in turn in what was commonly christened as table banking or *merry-go-round*. Chamas are good entry point (even captive audiences) for such initiatives as health, community insurance and other community mobilization schemes etc. (Nyangara, 2015)



Pic: A county governor launches ambulances [Courtesy of county news].



Pic:mbulance mashinani outside a rural dispensary [Courtesy Ahadi Kenya]

Recognizing individual effort

According to the founder Dr Stanley Kamau, before the Ahadi Trust came in the picture in 2007, jiggers' victims suffered rejection, altered self-image and generally stigma. Local leaders denied the existent of jiggers in their constituency. The community were reluctant being associated with jiggers and jiggers' victims. They felt that the anti-jigger campaign was detestable and demeaning to them. It was exposing something they were embarrassed of.

In some of these communities jiggers were associated with a curse or being bewitched. Every other

person, including health care workers was dismissive, but the passionate crusader kept on. In his own home area in Murang'a County he was declared a persona non grata. He was motivated by haunting memories his childhood experience being jiggers infested, being humiliated, and pain of being dipped in kerosene and Sodom apple juices to 'exorcise' jiggers-induced wounds. He like many of his cohorts who could not walk properly he dropped out of school at some point.

There was no known treatment available. Patients who had co-morbid issues that included jiggers, every other condition would be addressed except jiggers. Amid a lot of resistance the proponents of anti-jiggers campaign faced the campaign finally came of age. There was now a policy that outlined the preventive, treatment and rehabilitative activities.

There was now a role of administrators, community, teachers, health workers. Critical raising the socioeconomic status of the jiggers' victims. There was a fairly clear link between jiggers and poverty. Helping the affected people engage in some income generating pursuits was a big step towards eliminating stigma and jiggers at large. Every day amenities included making available pesticides, beddings, water, soap and foot ware. By mid-2017 Ahadi Trust had distributed about 6 million pairs of school to school going pupils in East Africa region. It aimed to distribute further 10 million shoes to children who walked barefoot to school. Ahadi Trust was now a recognized outfit with more than 30,000 volunteers, celebrities who wished to be enjoined in its activities included former Miss Kenya Cecilia Mwangi among others. Going forward they would be establish a museum to preserve the institutional memories of the anti-jiggers campaign.

The anti-jigger crusader had the last laugh. He got recognized and has been going places. The effort won various awards like an honorary Doctorate degree from University of Tennessee 2010, Warrior Award in 2011, Mother's Honors Award 2017, Global Leadership Management Award 2009 by USAID, Head of State commendation by President Kibaki in 2010. He was also nominated for other humanitarian awards including the CNN heroes award, African MDG achievers award

[Gleaned from Interview with Dr. Stanley Kamau in Kameme TV, *Kurung'a igiri,* 15th June 2017 9.00Hrs]

One head teacher from Ganze in Kilifi set aside one afternoon every term to give health education deworms and gives anti bilharzia prophylaxis. His story was highlighted by *K24* on 17th August 2017.

Likewise, residents of Kibera an informal settlement in Nairobi had learnt to solve their own problems in what could be referred to as grassroots economy. With diminished cash flow and purchasing power it was impossible to save, or attract credit. With the introduction of Lindi Pesa, a voucher-like community currency that complemented the Kenya Shillings.

With every local purchase made of goods and services (including healthcare and medicines) the transaction resulted in some proportional savings. It created fair financial inclusion, accountability, monitoring and access to microcredit since the more than 1000 members saved an average of Ksh 400,000 every month.

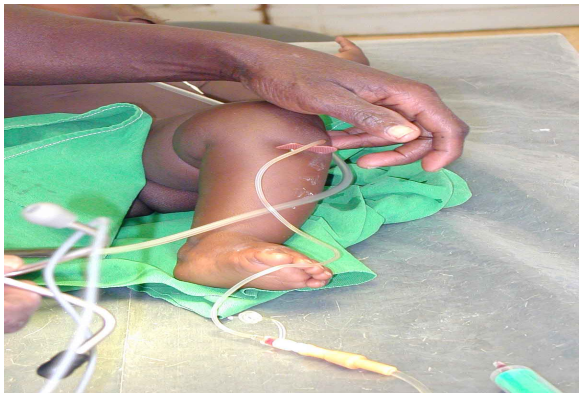
A saving realized this way could also go into a community health insurance, a community pharmacy (a type of Bamako initiative). Such initiatives could also be replicated elsewhere. (See **Recognizing individual effort** below)

As far as Millennium Development Goals (which used to be reviewed every two years), the following was monitored about Goals No. 4 and 5 by the year 2012. That the proportion of one year olds' who were fully immunized was 80% in 2011 against the 90

% 2015 target up from 78 % in 2009. As at 2011, only 43.8% of births in Kenya were attended to by trained health personnel or rather 43% of deliveries took place in health facilities against a 2015 target of 90 % (Mailu, 2012).

The proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) recognizes that in theory and agrees that quality health services can be provided in the most minimal service delivery setting as observed in Kenya Service Provision Assessment Survey (KSPA, 2004). See picture below.

KSPA further reported that overall, only 16 percent of health facilities had all the basic components to support 24-hour emergency services. To provide quality services, a facility must have the means to ensure that facility equipment and infrastructure are maintained in functioning condition.



Pic: During an emergency ability to do certain skills (e.g. an intraosseous using a scalp-vein needle) at the most minimal service delivery setting can save a life (Courtesy of Pan Africa Anaesthesia Symposium, June 2008, Nairobi)



Pic : Meteitei area of Nandi County is very hilly, inaccessibility of some rural health facilities as a result of poor infrastructure and poor road network (Picture courtesy of Leah Ng'eno).

Postscript: In recognition of the efforts *Chama Cha Wazee* male champions in maternal neonatal child health and elimination of mother to child transmission of HIV. In 2016 the World Vision Intl donated 40 beehives and 2 honey processing machines.

KPSA examined how well the district health management teams were meeting standards in the following areas: governance and management; human resource development and management; commodity management; infrastructure development; health care financing, budget and management; and performance monitoring.

Alongside this, KPSA observed that although it may be feasible to offer health services under a variety of conditions, there are certain infrastructure and health system components that were necessary for a consistent level of quality and appropriate utilization of health care services. Nevertheless our health system is inadequately designed and resourced.

Kijabe Mission Hospital was one of the busiest hospitals in Kenya. In the words of one Kenyan doctor who had done his internship there around 2012, the hospital did not have a lot of resources but they did amazing work, which was one reason there was hope that things could change. With discipline, teamwork and compassion Kijabe had made a difference.

The quality of health services delivered in public, private for profit (PFP), and private not-for-profit (PNFP) facilities are influenced in one way or another by several factors including: the distance to health facilities, availability of medications, equipment, and training of health workers among others.

Traditionally, the focus in low-income settings; among those expected to lead had been on the technical competence of health care providers, yet it has increasingly been recognized that: leadership, supervision, information dissemination and communication are major mediators and moderators of the quality and effectiveness of health care (Kabene, Orchard, Howard, Soriano, Leduc, 2006).

Many of the disciplines depended on the systems to transform them from trainees to professionals. It had become common knowledge among the health care staff that what determines their output has less to do with such like considerations as their level of training but much to do with where they will work. Where becomes a factor of production of bad, good or even better quality care.

The very same worker performed differently under different working conditions as evidenced by those who partake locum/moonlighting in different hospitals. 'How comes the same doctor or nurse is courteous to patients in a private facility but becomes recognisably hostile to those in public hospitals?' wondered a participant in *Kenya Health Forum* 2018, a 3-day event held at Laico Regency Hotel, Nairobi.

Findings by Smith-Campbell (2000) indicated that state policy does influence access to health care for the medically underserved in the community in a big way. For example, creation of Counties which are autonomous, decentralized management units that are able to plan and raise resources for defined services. With large-scale decentralization of governance to the 47 counties in Kenya, it was hoped that equitable allocation of resources and delivery of services (including health care) would follow. The following excerpt was gleaned from an online class discussion composed mainly of Kenyans that this author participated in. It formed a good fodder for thought.

The class discussion

'The most common array of organizations providing healthcare services in countries today are either public, private (for- profit) organizations, or private (non-profit) organizations'.

'In a free market economy set up, all three organizations compete with each other for the provision of services and where patients have to make a choice of which hospital to choose or be referred to'.

'Consumers are not strictly rational while taking decisions; there are many factors which influence their decision making. At times their decisions are heavily influenced by emotional, societal and psychological factors'.

'My concern would be what factors influence their choice for healthcare in private hospitals'.

'I am not so certain that there is competition between public and private given the perception of, ''better care and high cost" in the private. My opinion is that the competition mainly lies among/between the private institutions'.

'The reason for choosing private over public could be because of the varieties of commodities that are available in the private hospital than the public hospitals'.

'My concern would be focusing on what makes them choose one private hospital and not the other or public versus private'.

'Note that some public hospitals have established income generating units (IGUs) private sections, some are just amenities with some improvement on the general side while others could be private wings.

Some privates have ensuite sections and pavilions and this does have its own implications. Some wards in private are called general with others being private rooms. Some private patients utilize the general practitioners posed in the hospital while others choose their own physicians. In some private of privates the health care team constitutes itself and negotiates directly with the patient on the terms of payment while paying the hospital for the bed and some other utilities'.

'The choice for a patient who is subscribing to a lot to these insurance companies can easily affect where they go'.

'A free market economy offers such competition and the health industry has not been left out. I found it interesting because despite the fact that the private hospitals are damn expensive, they flock heavily with patients'.

'Recently the valuation of health by individuals in comparison to the cost of the health commodity seems to influence even the most irrational consumer. The free

market on the other end offers an environment in which the supply side has to put efforts to capitalise on the demand side. The result is exorbitantly priced health commodity yet so much sought'.

'I would like to know if there is a difference in health-seeking behaviour between outpatient and inpatient in public or private institutions'.

'This is very interesting. It seems more like the factors affecting demand for Healthcare services. An econometric model can be developed from this to determine future trends of demand for this health care services'. (Courtesy of online class discussion, Research Management and Communication Tools: Summer 2016, University of Washington, School of Medicine).

Constitutionally health services belonged to the county governments (under Sections 23 & 28 of Part 1 and Section 2 of Part 2 of the Fourth Schedule on the devolution of health sector of the Constitution of Kenya 2010). The Fourth Schedule of the Constitution explicitly defines county health functions, which include the management of pharmacies, ambulatory services, and health facilities.

Unfortunately some aspects of devolution for level 4 and 5 hospitals were effected through a legal notice (with lots political pressure especially from Council of governors) and not through a proper parliamentary process. A case was been filed by health care workers professional bodies to the Supreme Court to determine a way forward (matter pending by the time of publishing this book).

Reforms in the health sector especially the one divorcing the Ministry of Health from service delivery to that of policy and regulation was expected to further enhance quality of services delivery in the health sector. Yet devolution of healthcare services should not be viewed as a panacea for what ails the healthcare system. Instead, it should be viewed as a journey toward a "more perfect" system.

Its success depends to a great extent on the presence of an enabling environment, an environment that is marked by the will and commitment of all health stakeholders, a persuasive strategy that addresses the building blocks articulated in the KPMG report, 2014, and a well thought-out implementation process.

It was hoped that counties will not be to utilized as a tool to largely achieve political objectives but instead to act as instruments for: reforming the delivery of services (including health care), decision making that was more responsive to local needs, improving service organization by reducing duplication, increasing accountability and promoting popular participation to encourage self-reliance as earlier proposed by Gilson and Mills (1995).

The Ministry of Health, with support of various stakeholders, hosted a National Health and Leadership Congress from 23rd – 27th of February, 2015 under the theme:

"Transforming Healthcare in a Devolved System through effective Leadership, Management and Governance". The Congress brought together health sector stakeholders from national level and the 47 counties to benefit from expertise and experiences of local and international experts. Among other things it identified strategies to address challenges facing health leadership, management and governance in a devolved system to improve health service delivery.

Several community-initiated projects, including those funded through the Constituency Development Funds (CDF), some (including health facilities) over 10 years old were but empty shells i.e. unfinished, unfurnished, ill equipped, lacking relevant personnel or just under/unutilized, some even unwanted.

For those us who have ever had a chance to visit some of these health centres during community health outreach or facility inspections, the exposure to such sites was detestable. Counties were replicating the same mistake, launching costly projects which ended up under lock and key years after that. The nexus of policy-politics-economy is something else all together.

A disconnect existed between how we make our priorities, what the right hand (leadership) was holding, the left (the residents) might not know. The missed opportunities were obvious, what could be but was not. Such elicited the following reaction from an opinion leader in the area (see **The empty dispensary** below):

The empty dispensary

...an empty dispensary in a part of ... County for the last two months the clinic had been without a nurse. Generally rural health clinics end up playing an insignificant role in peoples' lives. The community willingly provides the housing, but the government often does not have the managerial capacity to honour its promises. Consequently, the supply of staff and drugs is either sporadic or non-existent.

Some parts of the statement in **The empty dispensary** were utterly surprising, like *they played an insignificant role in peoples' lives.* Anyhow I suppose this was what might be expected from a people who did not get what they want when they needed it.

The same could be said of community built pharmacies (the Bamako initiatives) and such like would be amenities that were waning. There was need to awaken the residents' hopes, hope in the spirit of self-help projects work. Quite a number of quality of health provision challenges could be solvedad ministratively (management and logistics).

A worst case scenario was that of closing down facilities that used to run on a regular basis. One year after devolution about $1/10^{th}$ of existing health facilities in the country became nonfunctional. This was observed by a World Bank study *Delivering public health services in devolved health system in Kenya*.

Consider the following five stories gleaned from media reports:

The Lamoe story: Elizabeth Lomoe was a volunteer community health worker operating several kilometres from Lodwar, Turkana County where she had worked for 25 years as a traditional birth attendant (TBA). She has since become a health visitor walking daily from home to home to appraise the condition of pregnant women, those who had delivered and were breastfeeding.

She had become an advocate for hospital delivery rarely ever conducted a home delivery. She taught mothers on early recognition of danger signs like anaemia, adherence to perinatal checkups among women in the neighbourhood. Her story was highlighted in the media.

The Nakoko story: on a remote village called Nakoko in Kabarnet, Baringo County. The nearest health facility was 40km away. About 22 health facilities had been constructed but were not operational due to deficient infrastructure, equipment and staffing.

Clinics were not always accessible, but when they were they were only good for simple check-ups, not for deliveries which could have been better and safer. If any deliveries were ever conducted in these facilities they were on adhoc emergency basis and mothers rarely spent the day there.

As a traditional birth attendant resident of Nakoko, 78 year old Chepkinyor Kitilit had for the last 60 years conducted deliveries in the vast region. She was doing a commendable job but mortality incidents due to of anaemia in pregnancy, postpartum haemorrhage, obstructed labour among others were not unusual. The maternal and neonatal mortalities statistics were disappointing. The Beyond Zero mobile clinics initiative was being called upon to reverse the trend.

It's to be remembered that parts of Baringo County essentially what was referred to as *Kerio Valley Triangle* had suffered insecurity for a long time. Bandits and cattle rustlers were killing, forcibly transferring populations, displacing people and creating uncertainty. For vulnerable groups like young girls trouble usually came in three's - threat of banditry, early marriage, and female genital mutilation (fgm) etc.

At some point humanitarian organizations like Kenya Red Cross withdrew their activities citing insecurity. It culminated into the vast area (consisting of 19 locations) being declared an insecure zone alias *operation area* from early 2017.

Around the same time the *sights and sounds* of Laikipia had changed into one insecure area due to invasion by herders into private ranches wildlife conservancy. The once hilarious northern tourism circuit had become a no-go, dangerous and disturbed zone.

A more than 8 months of devastating drought made things worse. The tourism industry had suffered major shockers due to uncertainties about security and travel advisory due to terrorism threat. These were factors that affected the health sector a great deal.

The Mandera story: The aftermath of the Mandera terrorism attack by Alshabbab militia in November 2014 led to many health care providers fleeing the county. The county has been working overtime trying to recruit hundreds of public service staff; the response was unlikely to be anything sustainable in the given circumstances (See **Campus Siege** in Chapter 17 and **Getting staff from within** below).

Getting staff from within

'Why would historically marginalized populations elect to eventually become health care providers (or teachers etc.) for the very system that (likely) underserved them in some way? Why would they elect to serve a system that would (likely) continue to underserve (in terms of health, education, representation, development, respect, and appropriate mentoring) their people? Whether or not this kind of thinking is rational or logical, it somehow explains some of the anger and frustrations in the discourse concerning why disillusioned youth from certain parts of the country resorted to crime and terrorism. This adversely affects healthcare provision to the affected regions' population in a big way (Source: Social Media).

The Lokuruka story: At Ng'ilukia dispensary in Suguta valley an Assistant Chief Wilson Lokuruka was treating the residents as insecurity forced the health workers to flee the area. It is to be remembered that 40 police officers were killed by bandits in the dreaded Suguta valley in November 2012. [It was unfortunate that it had not been made expensive enough to kill a police officer as cases (of 5 to 10) continued to be reported in the security operation zones all the way into the year 2017].

The nurse previously working at Ng'ilukia dispensary fled and relocated to Lokori in Turkana County. As was reported in one of the dailies on March 8th, 2017, the chief Lokuruka narrated, 'we usually communicate and meet when I ride to Lokori to request for more medicine and every time he guides me on prescriptions of various ailments'. Having previously worked as a community health worker with a Non-Governmental Organization (NGO). He said he could not watch his people suffer yet he could help with the little skills he had.

The Jila story: report filed from Kilifi County at the coast about Jila Health Centre. Its construction started in 2006 under the Constituency Development Fund (CDF) but due to what was alleged to be bad politics it had stalled, remained incomplete and underutilized. It could only offer the most basic treatment; deliveries could not be conducted there.

Though it had modern staff quarters it had no staff to occupy them. Modern equipment that had been delivered 4 years ago but had remained stacked in container casings, boxes and cartons. The health centre now served as a meeting point for people to conduct social events or in the words of a resident 'just to relax there'.

Ndigiria Health Centre 7 km from Jila was 'just a health centre on paper'. Its construction halted in 2002, fourteen years later the residents were still waiting. It had become a play area for children; graffiti on the walls was proof enough. The nearest operational health facility from Jila and Ndigiria was at Bamba approximately 20km away through rough road apparently lacking formal transport.

There was an old Giriama song that went like *...safari ya Bamba ni machero...* paraphrased from Swahili to mean - if you plan to travel to Bamba, then do it tomorrow, the journey was not for the faint hearted, the challenges of the journey were telling. The song was re-enacted by Muungano National Choir.

> **[Post script**: *By the time of publishing this book 51 kilometre Mariakani-Bamba road was 70% complete tarmac*]

I would like to quote a conservation documentary that ended with this clarion call *ultimately it's the responsibility of the Kenya government to protect its own elephants, but it cannot do it alone... we cannot allow the demise of the African elephants on our watch*. The county governments could not run away from this primary responsibility. A health facility was not a health facility minus drugs, equipment and staff. It could not be just a building with a meticulously done marble inscription at the entrance reading (see picture below).

This Health Centre was Officially Opened by Honourable ------ on ----

By early 2018 it was reported in the media that Kisii county had about 30 such constituency development fund (CDF) built but inoperational facilities. A unit of staff quarters' in one of them had cost Ksh1.7m but there were no staff in over 7 years down the line. Yet it did not operate, or else could mostly only be described as a beautiful building with no medicines. Leaders needed to do their part aggressively on behalf of the electorate. Citizens needed do their part in holding their leaders into account.

The following was perhaps an example of such effort: The Reproductive Health Care Bill, July 2014 brought to the house by nominated Senator Hon. Judith A. Sijeny. The Bill stipulated that: There shall be a level five hospital in every County responsible for offering county ref erral services.



Pic: Members of the community outside one of the inoperational health centre **(**Photo modified from Community Eye Health)

Each level five hospital shall have at least five ambulances. A level five hospital shall be fully equipped to handle-(a) child-birth emergencies; and (b) intensive care patients. (Sec 23, 24 of *The Reproductive Health Care Bill*, July 2014). The Bill concerned county governments in terms of Article 110(a) of the Constitution as it affects the functions and powers of County Governments set out in the Fourth Schedule. The issue of health care and especially provision of health facilities affect the functions of county governments.

Kenyans had witnessed the drudgery and redundancy of Parliament and the Senate house proceedings and it was not healthy for the country. We continued to witness supremacy battles between The Senate and The National Assembly (parliament).

By June 2016, it was reported that only 5 of the many bills originating from The Senate had gone through Parliament to reach the President's signature into law in the last 3 years. It might be possible that the *The Reproductive Health Care Bill 2014* could be one of the many bills sequestering in parliament or The Senate to date.

The quality of services offered by public and selected private facilities had been shown to influence the utilization of health facilities, and it bore a close relationship to the health care-seeking behaviour of the people. According to a study carried out in parts of the Kenyan coast, the poor sought care from public facilities while the non-poor or rich went to private facilities (Chuma et al., 2006). Nevertheless Marek et al., (2005) in an Africa wide World Bank study was able to document that 47 percent of the poorest quintile of Kenyans used a private facility once in a while like when a child is sick.

Sources indicated that on average a Kenyan earned Ksh 14,000 (USD 140) per month, it was then difficult to discern what was affordable to most Kenyans. In the case of Kenya's middle class, variously described as one able to spend on a daily basis between Ksh 2500 and Ksh 3000 (approximately $25-30 per day) 'without really feeling it'. A good number formed anchor clients for medical insurance companies and by extension patronized or else zoned high end private hospitals for themselves. But still for some of them, 'one was one medical catastrophe away from poverty' or bankruptcy.

Heshima- Promoting dignified and respectful care during childbirth

Heshima a Kiswahili word meant respect, honor, dignity, noble etc. This was a collaborative initiative spearheaded by Population Council, Ministry of Health, USAID, Federation of Women Lawyers of Kenya (FIDA), National Nurses' Association of Kenya - NNAK (midwifery Chapter) among others [www.Popcouncilorg/.../heshima] It aimed to investigate endemic abuse of delivering women by health care providers and develop inteventions. Practices which violated a woman's human rights and may discourage her from having an attended delivery in a health facility. In effect a major reason for choosing to deliver at home.

In its preamble page, it observed that disrespectiful and abusive care during childbirth which included: medical procedures performed without women's consent, discrimination, nonconfidential care, abandonment or denial of care, detention, physical and verbal abuse.

In the preliminary reports, 1 in women in Kenya had been humiliated, abused , hit or asked to bribe in their most recent birth. Nine out of 10 health workers reported to have heard or witnessed colleague treating women inhumanely. Some women in Magadi, Kajiado County reported pinching with scissors 'to hasten delivery'.

Apart from various articles published (Warren C, Ndwiga C., et al 2017) from the study media reports seemed to erupt with these sort of news on an almost regular basis . The KNHrot in early 2018 coming fast on the heels of this report.

2.5 Funding Health

Despite various policy initiatives, the health experience continues to be determined in large part by social economic factors (Mason, McIntosh, Bryan and Mason, 2008). Pariyo et al (2009) recommend that policy makers should consider targeting subsidies to the poor and rural populations while broadening public-private partnerships to increase access to health services among the vulnerable. Also see s**ection 4.9.2** of this book on Universal Health Cover.

Generally, there were great inequalities in the availability and utilization of services in Kenya due to these constraints as evident from the 2009 Kenya Demographic Health Survey (KDHS). These inequalities were a key issue for all health care providers. In a rejoinder on the national budget on health, the then Cabinet Secretary (CS) for health James Macharia warned that the funds allocated to the ministry were less than a quarter of what it needed.

This would impact negatively on provision of quality health care in the country. According to him the National Treasury in 2013/14 had allocated Sh34.7billion against the required Ksh160 billion. He was, however quick to note that the difference could be addressed through the devolved Government and development partners who were committed to assisting the country.

In the 2014/15 budget, to facilitate access to quality health services and to ease burden of the vulnerable and poor, the health sector was allocated Kshs 47.4 billion (out of which Ksh2.4billion would pay health worker's salaries).

To further support universal maternal health care Kshs 4.0 billion and a further Kshs 0.7 billion for free access to all health centres and dispensaries across the country, Kshs 3.0billion for lease of financing of health care equipment (leasing the equipment was the best option since maintenance cost was shouldered by the manufacturer who replaced them once they became obsolete, that is the trend worldwide), Ksh 0.67 billion to National AIDS control council, and Kshs 0.3 billion for slum health care program. These were big improvements though still short of the 160 billion the health sector needed (The National Treasury, June 2014).

Kenya had been moderately dependent on donor funds, many of which supplemented the development component of the national health budget. The United States was the largest bilateral donor, channeling funds through PEPFAR, the US President's Malaria Initiative, and USAID. Major health programs like TB, malaria, expanded program on immunization (EPI) and family planning continued to rely heavily on donor funding.

HIV/AIDS continued to be largely financed by development partners (who contributed 75% of resources), which posed questions with regard to the sustainability of

the Kenyan HIV/AIDS program should for any reason (and they could be many as seen below) donors were to pull out.

Every time you talk about health, you are talking about money and when you talk about money issues of corruption whether alleged or real seemed to come up. On May 4th 2017 the US cut over US$21million (approximately Ksh 2.1 Billion) towards the Ministry of Health due to alleged corruption and lack of accountability.

Largely prompted by the previous year's Ksh5 billion health scandals. Health CS had acknowledged integrity issues in the ministry that led to the cut. This suspension was going to affect direct costs in terms of administration e.g. salaries, wages, travel (local & international), meetings and workshops. Antiretroviral medications, nutrition support issues were not going to be affected as such. It was difficult to assume that this was likely to be as we come to terms, the effects would certainly be felt either way.

In 2006 external resources accounted for 14.8% of all health spending in Kenya. This was a far cry from the Abuja Declaration where African heads of states committed to allocate 15 per cent of their national budgets to health, but generally Kenya allocated only 5.6% to health. In order to plan and allocate the often meager resources, peculiar to the sub-Saharan Africa, it was important to determine what service needs were unmet (Adedigba, Ogunbodede, Jeboda and Naidoo, 2008).

May be there was need for political bilateral pressure to ensure this requirement was speedily met by member states. But then it depended on what it was the percentage was of. Ideally the percent allocate to health should be pegged on the recurrent expenditure so that an increase in one increased the other, but that was not always the case.

Baicker and Chandra (2011) acknowledged that, "In an efficient system, more spending on health care would be a sign of prosperity and a harbinger of improved health and longevity, not a cause for concern."

According Alex Ezeh, the Executive Director of The African Population and Health Research Center (APHRC): 'It was time to explore innovative financing mechanisms and partnerships with traditional and non-traditional donors, and also for citizens of African countries and donor countries alike to hold their national decision-makers to account in honouring their commitments' (*The Conversation Africa,* April 10, 2017). Could it be that funding aid programmes lessen the responsibility of elected leaders towards their own people and reduced pressure from the people to demand accountability?

The health sector was particularly vulnerable, yet US President Donald Trump protectionist policy had indicated cutting down on donor funding in a big way. His administration had hinted it would implement cost cutting decisions which had far reaching implications towards the health systems and world economy in general.

This included changes in US health systems like repealing the Affordable Care Act (Obamacare) in the US. In early 2017, the US announced that it was withdrawing US$32

million in funding from the UN Population Fund which directs money to family planning. This could have a devastating effect on healthcare in Africa.

President Trump dealt a major blow by ordering US agencies to suspend funding to Kenya in mid 2017. The Centre for strategic and International Studies indicated that the move could reverse the gains made in the fight against HIV/AIDS epidemic. Another source thought it could lead to deaths of more than a million people in Africa.

Jointly, the Global Fund and the US president's Emergency Plan for AIDS Relief (commonly known as PEPFAR) had turned the tide on the epidemic of HIV/AIDS in Africa. However in August 2017 the Global Fund was gracious to release Ksh36b for malaria, HIV and Tb to the Ministry of Health. This was a positive development.

About 6% of Kenyans were living with HIVAIDS and it would cost the patient Ksh 3000 per month (mid-2017) to purchase lifesaving generic anti-retroviral medications. A good number of laboratory tests were not covered under the donor funded program. He/she also needed about 3 square meals a day in order to cope with the high metabolism of the drugs in the body. Many patients could hardly afford 2 meals/day.

The free maternity care alone was projected to cost the government 12.5billion Kenya Shillings (Kshs) (~USD .125b) per year. The President of Kenya issued a decree on 1st June 2013, announced the removal of user fees and maternity fees from primary health facilities.

This was a big boost towards accessing affordable health care against a backdrop of only 10% (4 million) of the population with a medical cover in Kenya's 40 million people, more than half of whom live in rural areas. Private medical insurance were generally choosy, charges are high and may not cover some conditions like diabetes mellitus, HIV/AIDS and other chronic conditions.

2.6 Health Insurance

'For people with private or public insurance who have access to healthcare services, the melding of high quality primary and preventive care with appropriate specialty treatment can produce the best medical care in the world', Bodenheimer & Grumbach (2012) in reference to US health care system. The two authored the book *Understanding health policy: A clinical approach.*

If one is in a position to buy private health insurance, it is highly recommended to do so. As for everybody else in order to have some peace of mind, one must be in the National Hospital Insurance, albeit unaffordable it might be to a large section of the population, it is a basic minimum they are worse off without.

Disclaimer concerning NHIF: In the course of writing this manuscript the dynamics around NHIF benefits packages kept on changing. Sometimes within a short span, the author tried to keep up with the changes as they came. However it would not be his intention to misrepresent this great corporate if any of the facts were obsolete by the time of publication. The reader will be directed to countercheck the facts.

But how do we account for costs of all those people who have health problems but do not work or could not afford the Ksh500 (US$5.2) per month premiums for NHIF? (See **Now you have it, Now you don't** below).

Politicians and activists in Kenya had a way of misinforming their gullible supporters on issues that would otherwise benefit the common man (see **An essay: Why were there no medicines in Kenyan hospitals if there was so much else to show off?** in Chapter 3). Not even a trusted friend should tell you that you are better off without NHIF. One seasoned care provider put it plainly that, *as a Kenyan, you are better off as a subscriber no matter what*, *even if a study on corruption findings all came to the same conclusion about funds embezzlement in the national healthcare plan*.

I could not think there was a better way to put this. This construct would have failed its purpose if it did not over emphasize the importance of an individual mandate that requires every Kenyan to belong a health insurance. What if as Kenyans we could ensure that our aged and retirees will have the elusive medical insurance to see them through the sunset years? Provide subsidies to lower income groups and those who are high-risk (relative to incomes) (Feldstein, 2011; pp78-84).

> Although it had not yet been enforced, it became a policy by Kenya Retirement Benefits Authority that each pension scheme establishes a post-retirement medical scheme. They saw that it was nolonger cost effective for retirees to access health services at the staff clinic. They should be able to access it from anywhere.
>
> Personal savings and pension awards were inadequate to sustain a medical catastrophe. In Kenya the employer and the employee were mandated to come up with a 30% of employee's income as contributions towards pension, the employee made a mandatory 7.5% but it was upon the employer to top up the 22.5%. Many employers rarely made past 15%. Employees through their pressure groups had to lobby. Essentially this meant that the savings could not be much after all. Some employers deducted but failed to remit the contributions to the fund managers.

I have already said this severally but I will say it again, health insurance is health insurance, it does not matter whether it's the national, private, or social welfare type etc. Having insurance may not necessarily mean that access to and utilization of care will ensue… Some significant access barriers may still be present as seenn below.

Some providers may not accept the national health insurance card; the waiting may be unbearable even to the point of creating a stigma to the holders. This is the hard truth, perhaps a disincentive. But then the options get fewer if one looks down the economy ladder and it seem to happen everywhere too.

An example is Medicaid policy holders in US. Medicaid is meant to improve access to health care among low-income populations. Without a policy on universal healthcare it was not a wonder that with all the plenty within their borders US still experiences a challenge in alleviating these barriers. Can Kenya afford universal healthcare? Is it in the vision 2030? If not can we slip it in?

Lack of health insurance has adverse health outcomes. Insurance works by healthy people buying it knowing that they could need it. Insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable, relatively stable over time by striving to have in their pool clients whose health on average are the same as that of the general population.

When someone in their group gets sick, then the sick person only pays a fraction of the

cost. As such an insurer would like as much as possible to make insurance available to those who will not need to use it and where known calculate it based on their risk level (risk adjusted premiums) (Feldstein, 2011; p80).

Unfortunately again healthy people (e.g. the youth) may not have insurance for several reasons among them joblessness. If healthy Kenyans decline to obtain health insurance and sickly people, not previously covered with health insurance, jump on the band-wagon and obtain health insurance, insurance companies would face tremendous expenses.

Long term care (e.g. in nursing homes) is very expensive, so an insurer anticipates "shelling out" a lot of money for the insuree to help pay for that expensive care. With this anticipation, the insurer wants a lot up front just in case. Really no one would wish to insure a home against fire knowing too well it was already on fire or if it stored combustibles and there was no fire engine in the vicinity.

People buy insurance to obtain help with future costs. The biggest revenue driver of the private health insurance companies are healthy individuals who never end up using the health services but continue to pay for insurance (See **Pay as you earn vis a vis pay before use** below).

A person in ill health will attempt to conceal that information so that the insurer will not know of the higher risk (adverse selection) some of these individuals end up being abusers of the system. An individual with pre-existing condition is considered higher risk because that condition may make him need more health care services which will cost more.
Unless restricted by regulation insurers were more likely to charge higher premiums to individuals who are likely to incur more (*HealthAffairs* Nov 30, 2010).

Conversely people who know they have a problem (those with pre-existing condition) are more likely to seek health insurance than those who either don't have a problem or don't know that they do (Claxton, 2002). To mitigate against this risk, insurers: create categories of eligibility, restrict enrolling, set limits on benefits, a clause not to cover pre-existing conditions, having client cost sharing on some services, having a period within which one is contributing but is not eligible to benefit before the expiry of such a period, having a separate drugs/services deductible (deductible = an amount that the insured person is responsible for paying out-of-pocket before the insurance plan provides cover for the services) etc.

Now you have it, Then you don't

R.W, a 75 years female was admitted to a level 5 hospital in critical condition for what was diagnosed as partial intestinal obstruction, with severe dehydration. She was the only beneficiary named in the NHIF cover; she and her husband were peasant farmers in the rural part of Nakuru County. The husband had been innocently servicing the family NHIF card at Ksh160 per month from April 2015 to December 2015 thus owing Ksh 340 per month. For some reason they were unable to pay from January 2016 to April 2016 (Ksh 160 used to be the statutory monthly but wentup to Ksh 500).

This meant they owed Ksh500 per month on top of a penalty of Ksh250 per month (for the three months) accrued that they had not paid anything (excluding April which was the month FW was admitted. The total amount owed to NHIF was coming to Ksh5060 which they did not have. They opted to pay for every service out of pocket. From Friday to Sunday (2 full days) the bill plus came to Ksh2800. Paid admission fee, an abdominal X-ray, purchased some drugs like x2 enemax, x1 syrup lactulose from pharmacy spending some Ksh900 outside the hospital since they were not available in the hospital.

She was not that well even on discharge. She had only opened bowels once 'slight'. Little did they know that she would be readmitted the next week from Wednesday to Friday, the obstruction had not resolved and she was in a lot of pain. Same story, bought x2 enemax and lactulose. This time she got much better, was discharged on lactulose. They paid a bill of Ksh1900. That aside RW was being followed up in the dispensary and a private clinic.

A few days prior to this first admission she had also been treated for acute tonsillitis put on been on caps Amoxil® then tabs Augmentin®. Upon inquiry it was noted that for her hypertension she was on tabs Lasix, tabs HCTZ, tabs Brufen®, tabs Adalat® all out of pocket. By the time of writing this excerpt the couple did not have any medical cover, even the taunted super cover NHIF was out of reach. This may or may not be a typical patient but the circumstances are similar to what many Kenyans go through every day. Moreover what would be so hard about reminding clients that their premiums are overdue and by how much and any changes in the policy thereof including the amount of premiums payable. This couple might have benefitted from such a concern. Ignorance would appear an unreasonable phrase to use on such an elderly couple with such presence of mind. What with the out of stock medicines or reagents in many health facilities?

(The client was interviewed together with her significant other by this author, consent to

share information granted, identity protected)

Supa Cover

NHIF *Supa Cover* now covered in and outpatient, maternity, rehabilitation, chronic conditions like cancer, diabetes and, hypertension. Renal dialysis, full course chemotherapy and radiotherapy. It also covered laboratory and investigations to include MRI, CT scan, X-ray etc. (*NHIF supplement cerebrating 50 years).* One beneficiary SK on Tuko.co.ke blog observed '…Kenyans facing tough personal battles could focus on recovery free from financial fear'. In October 2015 NHIF waived some of the defaulted rates for 12 months if the affected members paid Ksh 1500 and then continued contributing.

Pay as you earn vis a vis pay before use

'I'm grateful to be healthy, but then again why am I paying for this health insurance that I'm not using. Again, it doesn't seem fair. In the end, it's all based on risk assumption. And I would rather have my safety net, my health insurance (probably like most people) than not and risk something happening'.

'…I am happy to pay for lots of services that I and my family will never use. A case in point is paying taxes for schools… My wife and I will never have kids, but I'm happy to pay for this for the betterment of society'. [Two friends from US shared on a blog discussing health insurance]

On 2nd November 2017, NHIF enhanced benefits changed provider model for outpatient services (OPD) from capitation to fee-for-service model. This meant portability of the benefits so that a member could access care in any of the 2000 plus accredited and contracted (public, private or faith based) health facilities. Apparently this applied to the self-contributing members; it also excluded those being treated for chronic conditions like diabetes. It would not be necessary for one to choose facility upfront for OPD services. However a couple of weeks earlier they had indicated that the number of OPD visits would be limited to 4 per family each capped at Ksh 1500, this had raised concern among Kenyans.Kenyans on Twitter petitioned that 'it was like asking members to choose when to be sick and how often' also had a battery of punitive requirements which would disenfranchise many beneficiaries.Some thought it was looking for faults. COTU, the workers umbrella body objected to the move.

The CS Health suspended this notice which was to take effect from 1st November 2017. Some reasoned that for self-funding the figure 1500x4 visits =6000 was equivalent to their cumulative 500x12months =6000. For some 1700x12 =15,400, limiting to 1500x4visits =6000, was ridiculous. Much as the public felt short changed they would eventually have to choose from the four dimensions (quality, access, cost, choice) each a trade-off the other. Whether to keep the benefits of the supa cover with the limit of 4 outpatient visits and foot the rest out of pocket or unlimited OPD visits and a curtailed supa cover.

A lot of savings can be made on pharmaceuticals and outpatient services. These restrictions rarely apply to those who have corporate cover through their employers, largely because they are seeking insurance as an extension to being employees. Moreover the reasons they got the job was based on other parameters and not the medical insurance benefit.

Medical cover is not 'free care'. Insurers would like to as much as possible be parsimonious in terms of spending. Some of the precautions they institute are meant to discourage spending by letting a consumer make conscious decisions by exposing them to financial consequences of their choice where possible (Claxton, 2002).

When the insurer e.g. NHIF operates as a pay-as-you-go basis fund, current expenditures are funded by current contributions. Current contributions usually are not set aside for future expenses; instead they are used to pay for those beneficiaries who were eligible at the time the funds were collected. The overall number of contributors (mainly workers) to beneficiaries' ratio at any point is critical.

The fund covers the contributor, their declared spouse(s) and five children who are of dependent age (s). These demographics as well as how beneficiaries make decisions concerning their health care are vital for the success of the fund. They can also create some unforeseen effects such as cash-flow shortfalls when they do not remit their subscriptions on a regular basis.

There should be ways of predicting sustained revenue over the long run without substantial shift on spending. In case the fund were to become insolvent i.e. current contributions collected is insufficient to pay current expenditures it would be a challenge. However for the national fund with a fairly stable cash flow from contributions on formal employment pegged on a percentage of gross income this scenario is less likely. The same cannot be said of a private insurance company. But it could still happen. For instance on 23rd October 2011, *Business Daily* reported[4]

> *'Rising medical claims and wages were eroding the cash reserves of National Hospital Insurance Fund, a trend that could make it difficult for the public insurer to meet its obligations. Its surplus had shrunk from Sh990 million in 2006 to Sh173.4 million last June in a period that had seen salaries and claims more than double'.*

Temporary increases or fixes to override demand would be least welcome by NHIF contributors. No point asking Kenyans to be ready to make sacrifices when their lack of confidence in the integrity of the fund is still in their short-term memory. It would undermine the credibility of the fund by engendering uncertainty and frustration among accredited hospitals and by extension the beneficiaries.

A comprehensive medical cover: an inch wide, not deep enough either.

SM worked for a parastatal organization some 250 km away from where his family of six lived. As an employee he was entitled under 'senior staff category' to comprehensive medical cover which included his family. This was in selected hospitals and high end clinics within a certain radius and a few in two other towns. His town had good hospitals but efforts to have one appraised had not been fruitful for the last 5 years that SM had worked for the organization.

It was either that if any member of the family was sick, would have to travel to the selected hospitals or the staff clinic 200 km away. The other option was get a referral note to the hospital in his home town, emergencies notwithstanding. Even with a referral note, it meant having to pay out-of-pocket to foot the bill and then launch a claim for reimbursement.

The last time which was over 3 years ago during the delivery of his last born daughter, he paid Ksh 60,000. It normally took a couple of months to have these claims scrutinized and processed to a refund cheque. At other times he needed to accumulate a substantial value in terms of payments receipts accrued before launching the claim.

These requirements often constrained his family from seeking timely, quality medical care and making do with over the counter treatment (OTC). Chemist was easier- they see you somehow, prescribe and sell to you the drugs. Consultancy was expensive Ksh 2000 to 5000. It was also possible to *Google* and get to buy 'OTC' what Google recommended; be it antibiotic or otherwise without the need for a prescription. Going to public hospital was out of question with long queues; need to have someone to connect you to jump queue, laxity, and constant medics' strikes in different towns meant he could not access quality medical care either.

SM's wife suffered a chronic back pain and high blood pressure. His ten year old daughter was known asthmatic. SM collected their pills and inhaler from the staff clinic regularly. Due to all these shortcomings on his medical cover, SM was considering taking another medical cover.

The easier option being to revert exclusively to NHIF which he was by default a principal contributor with a monthly deduction of Ksh 1700 per month but had not needed to rely on. However, he was later to learn that the private facility had chosen could not offer the dental attention needed by his 10 year old daughter and ear-nose-throat (ENT) care for the spouse. Seemingly the *OK* tick was missing for dental and a number of other key areas. As for the ENT, the hospital did not have a resident specialist.

The season was heading to a long weekend and so both the NHIF office and Huduma Centre desk did not operate during odd hours. That meant 4 days (or perhaps more) of delay in getting the needed care. Telephones were out of question, they too were unanswered or inaccessible.

Aligning the beneficiary expectations with those of care providers has the potential to improve health, control costs, improve care coordination and the experience of health care as provided through the health insurance. It can also reduce cases of fraud, waste and abuse of the fund's resources eroding NHIF cash reserves.

The members of public would have to be safeguarded by government regulations through Insurance Regulatory Authority (IRA) under Insurance Act cap 487 which includes financial standards, quarterly and annual reports on reserves, minimum capital, investment practices, obligations that would be required of every insurer to be in business. IRA also handled customer complaints and disputes.

If Kenyans who had private insurance, and then all of a sudden a new public program (in this case a well-managed national social health insurance) is created, making many of them eligible, would they abandon theirs and take up the new program? Yes, this is quite likely for many especially those who are unhappy with their present voluntary schemes. NHIF should maximize on this opportunity by ensuring participation, or "take-up," among eligible adults exceeding current subscribers.

[4] 23rd October 2011, *Business Daily* (Nation Media Group, Nairobi) Rising Claims, Wage Bill

Such a scenario could be exacerbated by the dual eligibility status of some of subscribers. It is likely that some of them with more than one insurance, if not all of them, will drop the private insurance. This phenomena is called the 'crowding out effect' (Claxton, 2002; Feldstein 2011).

This will be especially likely for those in the higher income bracket (gross income = Kshs 100,000 and above) whose deductions are Ksh1700 per month to NHIF (its mandatory for those in formal employment) if they were allowed to choose better hospitals within their geographical location. Fortunately by mid 2017, some of these contributors expressed that *NHIF seemed to have 'more money' than it was disbursing since some people contributing to it also had private insurance and hardly utilized it.*

There ought to be a balance between premium subsidies for those who cannot afford and penalties for those not taking up coverage. More important though, is a need to remove flawed medical products and accelerate efforts to control the costs of health care services. First by holding providers of care accountable for costs and quality of services they provide before paying them. These were the primary determinants of the cost of health insurance in all markets, including employer-sponsored, individual, and public.

By January 2016, Mr Mohamed a senior officer with NHIF said that membership to the fund had grown tremendously over the years from about 3.7 million in 2013 to close to 6.6 million by mid 2017 (approximately 18-24 million covered if you consider the principal contributor with dependants).

They saw a need to refocus on a business model that zeroes in on voluntary contributors, hunt for them by positioning themselves as hunters. The informal sector offered ample potential which was unexploded. Some of the ways proposed included customer service and support, publicity, contracting service providers who could deliver high quality service which had a high value for money.

Residency becomes another requirement for access & utilization (if not eligibility) of NHIF especialy the inpatient package. This raises the question; if someone is a resident in *Q*, should he/she be allowed to use hospitals funds from *R* for his/her care purposes?

Private insurers would have to come up with incentives like reduce their premiums rates to remain in business, strive to reach out and maintain employer sponsored coverage. They would have to create incentives packages and preferentially market to attract their beneficiaries. The landscape has become more competitive, the public insurer reaching out to the uninsured as well as those already insured.

Employees can also opt out of the employer sponsored corporate insurance, claim their medical allowance and opt for the public insurance instead. One thing to consider about "crowding-out" is that some may not give in to public insurance because of the stigma associated with receiving NHIF only, NHIF is taken by some to be common man's thing, and the long queues in some accredited facilities does not mitigate this undertone. Some might fear the lack of providers accepting the NHIF card in some instances.

NHIF also operated on a more or less pro-rated capitation payments basis to the providers which at times these do not add up to rebates/reimbursements. There was also the ever present fear of relegation to a lower level provider. But for Kenyans the biggest apprehension was the fear of corruption that bedevilled the NHIF of yesteryears.

Apart from that, administrative costs previously used to consume half of the members' contributions, but things have changed. There was proof that NHIF had given hope and eased the sufferings of many Kenyans (see Social Insurance and Subsidies below).

But first things first, NHIF needed to do more in easing the expected burden of the enrolment process to be least cumbersome. It had somehow achieved that by having online membership registration, networking the over 2500 accredited health care facilities, decentralization to 98 service points, having its services integrated into the one-stop 40 or so *Huduma centres* countywide though it was interesting that the organization closed office over weekends and public holidays.

Introducing diverse options for payment of premiums through: mobile cash transfer; electronic fund transfer (EFT), *e*-wallet, having a more responsive customer care at all points of service; as provided in the customer service charter - a USSD code *263# and 21101 query member account short message reminder system etc.

As to how efficient these were was another matter altogether. The USSD code requested users to supply a PIN. The toll-free line was unattended sometimes while some of the quoted numbers in the service charter were either not in service or were unrecognizable by mobile networks (**caveat** - at least for the times this author tried to access that was the case). This is not to say that the insurance was not upto the task with numerous encouraging testimonies.

2.6.1 Social Insurance and Subsidies

> JG, a 30 year old, university student was diagnosed with end stage renal disease (ERSD) after a complicated glomerulonephritis. He was undergoing renal dialysis sessions in two of the leading hospitals in Nairobi awaiting kidney transplant in India. He was looking forward to raising Ksh3m.
>
> When his case was highlighted in *Family matters*[5] in a leading national television station, this was what he said concerning NHIF. *'In the past it used to be that each dialysis session would cost Ksh7000 and one needed 2 sessions per week, now as long as you have an NHIF card, no hustle, they just pay for you, I thank the government for this'.*
>
> He stated that his biggest fear was not the cost of transplant even though the family was fundraising; the biggest challenge for transplant recipients was the cost of the anti-rejection medicines. These would cost on average Ksh40,000 per month, yet one needed to use them for life. He urged the government to consider subsidizing these medications or provide them for free as was the case of antiretroviral (ARVs) drugs.

Under Category A (government hospitals), members would be able to enjoy full and comprehensive cover for maternity and medical diseases including surgery. In short, they would not need to pay for anything on admission provided they are fully paid up members of NHIF.

Members admitted under contract Category B (private and mission) hospitals will enjoy full and comprehensive cover but where surgery is required, the contributor may be required to co-pay. Those visiting facilities contracted under Category C (private) would

continue with the current system where NHIF paid specified daily benefits under the this arrangement.

It did not make much sense many people that they were being asked to go and purchase medicines or meet the cost of some services themselves despite having an insurance cover. A co-insurance bill (out of pocket cost-sharing over and above what the insurance plan covers) in many cases was still way beyond what many Kenyans could can afford. This aspect was something about medical insurance that many failed to comprehend. Thus many of these policy holders ended up being limited/relegated to a lower tier of the health care system, usually the same public hospitals that those without any cover go to.

The ability to make choice of preferred NHIF accredited hospitals which included public hospitals was meant to streamline services. An elderly subscriber who happened to be diabetic and hypertensive had a rude shock when the hospitals he had indicated as his preferred could not treat him. He needed dental care for a toothache with possibility of tooth extraction.

None of the hospitals was willing to treat him for some reasons better known to them. So he ended up in the level six public hospital where he had to pay out of pocket to be attended, why it was not among the choices he had previously made or rather as paraphrased in Kiswahili he was categorically told *hukuchagua uwe ukitibiwa hapa*. Private hospitals constituted an estimated 50 per cent of the country's health care system. The Kenya Association of Private Hospitals (Kaph) is the national association of medium and small private hospitals in Kenya. They claimed that the Ksh1,200 capitation allocated to them for outpatient services per NHIF member was inadequate and unsustainable.
It was alleged that some private facilities had started turning away patients seeking outpatient treatment under the State cover arguing the Ksh1, 200 capitation per member is unrealistic and unworkable for a whole year. They had been clamouring for the increase of the capitation per patient to between Kshs 6,000 and an ideal Kshs 20,000. However NHIF in a rejoinder said that the cover was enough to treat patients[6]

From a business sense point of view, it has been argued that private insurance tended to cover healthier people, thus the percentage of expenditure is far less than the percentage of population covered, many being required to pay out on average less than 50 cents for every shilling collected as health plan premiums.

Ideally there ought to be a relieve on taxation for both employer and employee to monies contributed directly by check-off to the health plan so that it has fairer value in health benefits than money the employee first earns, is taxed and then he uses it to pay for health insurance. Again there ought to allow portability and continuity as workers moved from one employer to another or become self-employed (Bodenheimer & Grumbach, 2012). They added that a good national health insurance program must interact with existing health care program whether employer schemes, corporates or private insurance plans.

[5] KBC Channel 1 TV *Family matters*, 29th May, 2016 22Hrs
[6] Daily Nation, Wednesday, October 14, 2015 http://www.nation.co.ke/business/Rates-enough-to-cover-patients/-/996/2913252/-/6lj18g/-/index.html

An insurance card is evidence that the client can afford the health service; they can also access the care when they need it (timeliness). Health care providers generally know that when they treat people with a health cover they are likely to be paid for the services rendered within reasonable time.

It had been observed that as soon as a family in Kenya got into Kshs 40,000 per month, they tended to pull their children out of public schools into private schools. The same however could not be said about medical insurance or medical care. Most of these families continued to receive care in public health facilities.

It had been observed that without medical insurance cover, medical care could wipe out all the retirement savings of many a senior citizen, yet many elderly persons somehow felt some form of discrimination by many medical insurance companies.

NHIF, the public health insurance is open to all Kenyans, covers all conditions and maternity charges. However, only Kenyans who were formally employed and whose income exceeded a set threshold hitherto participated in the National Health Insurance Fund (NHIF). Retirees had to continue being active NHIF self-contributors after leaving gainful employment.

The national government along with County governments through the Ministry of Health had expressed interest in providing health insurance to the elderly. Where this is so to what extent did the government sponsored health insurance cover impact on out-of-pocket expenditure among enrolled elderly say within 1 year of implementation. This would form a good piece for research.

Government financed health insurance can be divided into two categories: Under the social insurance model, only those who pay into the program, usually through social security contributions, were eligible for the program's benefit. Under public assistance (welfare) model, eligibility is based on a means test; those below a certain income may receive assistance; those who benefit may not necessarily contribute, and those who contribute (usually through taxes) may not necessarily benefit (Bodenheimer & Grumbach, 2012). The proposed scheme for Kenya is skewed towards social insurance model, which leaves a great deal of Kenyans without any medical cover whatsoever.

It is to be noted here that most people who can, obtain health insurance when employers voluntarily decide to offer group coverage to employees, their families to help pay for the costs of health insurance. There is a cycle-in-cycle-out insured/uninsured fleeting benefit.

Those who lose their jobs also loose the cover since few could afford to service the same rates of premiums as individuals. If and when they get other jobs they might come back to the scheme. One such confessed that when he tendered his resignation, even before he started the clearing process his former employer urgently demanded he surrendered were all the health scheme's identification cards he previously held, and by extension those of all his beneficiaries.

The employer was not taking any chances, health had to go first. He was now a serious liability to the company. The terms and conditions of the contract with the corporate insurance were more than clear on this. This left the former employees and his family in a vulnerable window period with no cover during this transition.

For many Kenyans some form of medical cover was better than none at all, and it did make a lot of difference. However, there was need for prior understanding as to what the benefits and limits of the package were by asking a lot of questions before signing the contract.

It would important to mention here that medical insurance based on daily check offs through mobile (phone) money transfers would be feasible building on past successes stories of *Mpesa® - Paybill, buy goods & services, M-Kopa®, M-Akiba®, Equitel®, M-Shwari®, Airtel money®, an interbank money payment switch - PesaLink®, Orange money®, MobiKash®*, *Tangaza®* etc. By and large they had apparently failed to fill the gap of reaching out to the uninsured.

Bur something seemed to go wrong after their hyped advertisements and subscriptions by a section of Kenyans. They come and go without substantial evidence as to their impact in improving access to health care.

Unfortunately for the clients it became difficult for them to keep up with their part of the 'flimsy' contract and ultimately the insurers had 'good reasons' to keep the already raised premiums and terminate the contract. There was no evidence available to date as to what proportion of mobile phone subscribers enrolled and how far they have gone with servicing and benefitted from the mobile check-off health insurance.

Nevertheless, there was one innovation seemed to be working was *M*-Tiba which was launched in December 2015 and by September 2016 had 45,000 people registered. It had been nicknamed *the mobile health wallet*. It was a partnership between Safaricom, *UAP* insurance, PhamAccess, and CarePay. A member had to be 18years of age and above, with a registered SIM card. Registering was by *253Harsh tag, transaction was free.

Through the social platform, a member could save as little as Kshs10 for self, relatives and friends. The stored funds would be channelled between funders, patients, health care providers (private and public) and even doctors abroad. A lipa na Mpesa (transfer cash electronically) through pay bill number *XX500066* with the account being the cell phone number. A toll free line *+0800721253XXX.* Their website URL *www.m.tiba.co.ke*. This is an area that holds lots of potential for uninsured Kenyans.

Kenya had witnessed a positive change in financial inclusion in terms of access to financial services through the rollout of the agency banking model in May 2010. Commercial banks contracted varied retail entities to offer basic banking services on their behalf. The contracted entities include security companies, courier services, pharmacies, supermarkets and post offices and grocery shops, and individual standalone kiosks etc.

Brands that stood out included: *Equity Agent/Eazzy Pay, KCB Mtaani, Posta Mashinani, Co-op kwa jirani, Family Bank Pesa Pap* among others who acted as third party agents to provide cash-in-cash-out transactions and other services in compliance with the laid down guidelines. This had reached the previously unbanked population, made access to instant credit through Benki mkononi (bank at hand) *m*Banking a reality. This coupled with the almost ubiquitous presence of affordable mobile phones and cellular networks.

Central Bank of Kenya reported that as at 31st March 2016, there were 17 commercial banks that had contracted 40,224 agents which had facilitated over 170.5 million cumulative transactions valued at KSh 930.2. The *block chain* revolution using cryptocurrency had also spread into various commercial applications:- e.g Bitcoins

had started being accepted as a public ledger in some transactions by late 2017.

In Kenya, the public health facilities have adopted a cost sharing concept where the patients pay a nominal fee for some services or at cost value provided by the facility. The policy of cost sharing was meant to bridge the gap between actual budgets and the level of resources needed to fund specific public health sector activities.

Funding from the government was in the form of a Health Sector Services Fund (HSSF) that caters for the daily running of the facility. Cost-sharing is seen as a way of revenue generation to supplement government allocation but according to Bodenheimer & Grumbach (2012), the primary intent of cost sharing at the point of service was to discourage patient demand for services as a cost containment measure.

When the individuals had insurance coverage they were more likely to use services than when they had no insurance. Therefore even for the later some form of out-of-pocket (as stipulated in terms and conditions of the contract e.g., some services might fall outside the medical cover) became necessary for the same reasons mentioned so that they could pay directly for some portion of their health care.

Efforts to reform the National Hospital insurance Fund (NHIF) and to extend its services to a greater portion of the population through the creation of a National Social Health Insurance Fund had failed to take off for a couple of years due to political and labour unions opposition, contributions were expected to be done per head and not per family.

Proponents envisioned the fund as a "pay-in-advance" insurance scheme that would enable a greater number of Kenyans to set aside funds for necessary physician visits, medical procedures, and pharmaceuticals. But private medical associations opposed the reform on the grounds that the scheme would designate preferred providers and facilities, causing their members to lose business from "pay as you go" clients.

Although civil servants and teachers generally enjoyed better perks than those in the national scheme, their unions mobilized against the plan because members did not want to forego receiving their medical benefits as cash disbursements, which some 'used' to supplement their salaries.

The employees felt that health insurance premiums were part of the expense to the employer rather than cost borne to themselves as employees as foregone wages. The trade unionists argued (and this is true according to Bodenheimer and Grumbach, 2012) that many employees might receive higher salaries/wages if the costs of health insurance were lower.

This meant that the national scheme would have to weather and survive legal and political challenges for Kenyans to realize its noble intentions. For example, the Central Organisation of Trade Unions (COTU) and the National Hospital Insurance Fund (NHIF) needed to agree whether contributions to the fund should be pegged on an employee's basic pay or gross pay.

In the National Social Health Insurance Fund: For those too poor to pay, the government would pay for them. In its tenth year of phased implementation, the scheme would be targeted to give comprehensive health care to 80 percent of the population. The sources of funding would include payroll harmonisation, general taxation, informed sector contributions, donations and grants. The scheme was outlined in Sessional Paper No. 2 of

2004 (Ministry of Health, 2004c).

The government intended to move the free maternity Kshs 4.6billion cash to the NHIF following claims of mismanagement of the funds by various hospital authorities. This was part of the government's plan to restructure NHIF operations in readiness for the provision of universal health care.

Approximately Kshs6000 per expectant woman covered delivery, 4 antenatal checkups and post natal checkups. Its intention was in looking at it like an insurance package for effective management and utilisation. Free maternity services were one of Jubilee's administration's flagship pledges in the 2013 election manifesto. The decision to move the funds followed intervention by President Kenyatta who was said to be alarmed by reports of financial impropriety regarding this landmark jubilee project.

NHIF being a parastatal under the National Executive, the move was likely to open another battleground between counties and the national government over devolution amidst concerns by governors that the national government wanted to take back some of the functions assigned to them. The county governors cried foul over this perceived side-lining of their role in of matters health yet they were Chief Executive Officers at the county level where devolved health services fell.

By June 2016, the governors continued to complain of delay in disbursement funds for the free maternity from the national treasury, and even threatened to start charging the mothers by December 2016 unless things changed, the treasury on the other hand claimed the funds were being released on time.

There was a definite push and pull between the government and counties for the control of billions set aside for health. It was difficult for the common man to know who was giving the facts as they were and it all meant to the future of the free maternity program.

On 14th January, 2015, President Uhuru Kenyatta launched the Civil Servants and Disciplined Services Medical Insurance Scheme. This targeted about 900,000 people since in this new scheme the contributor's declared spouse(s) and five children up to the age of 25 are also covered. The Ministry of Devolution, NHIF, Kenya Red Cross and AMREF Flying Doctors had partnered in the initiative.

This was an important enhanced cover in addition to what was being offered by NHIF. It included other benefits such as 24-hour call service, pre hospital care, medical evacuations and hospital transfers. Also includes treatment outside the country.

In a related development, Teachers' Service Commission (TSC) in circular dated 22nd May 2015, TSC had partnered with *AON Minet*-Kenya[7] to institute an insurance scheme for teachers who numbered of 288,000.

All teachers actively in service from eighteen (18) years to mandatory retirement date are eligible for cover; One (1) legal spouse of the teacher; Four (4) dependent children (biological/legally adopted) are eligible for cover from birth until the age of eighteen (18) years or to the age of twenty (25) years if residing with their parents and enrolled in a recognized post-secondary institution; No age limit shall apply to child dependants with disability. During the 42 nd annual general meeting of secondary schools heads in mid 2017 contributors observed that *AON+NHIF* twin scheme was costly and apparently not harmonized.

Offering Outpatient unlimited; Maternity at a flat rate of Ksh75, 000; Inpatient cover went up by half (from between Ksh300, 000 to 1 Million); Dental care Kshs 20,000 - 25,000; Spectacles Ksh93, 652. Other benefits included health education, 24hour psychological telecounseling. Retired teachers also became eligible.

The top 10 morbidity and mortality affecting teachers in from most ailments to the least Road traffic accidents related injuries; Malaria; Uterine fibroids; cancer; hypertension; Pneumonitis; Anaemia; Hernias; Meningitis and Kidney disease. In a review a year in May 2016, some of the achievements included improved health of teachers and their families; reduced death rates (517 compared to 1200 the previous year). A total of 683,451 teachers had visited the Out-Patient Department (OPD) since July 2015; 18,058 had inpatient visit; 56 had been treated overseas (mainly India).

Some of the challenges facing implementation of the scheme included misuse, fraud, overdose, congestion in preferred facilities, difficulty in controlling cost, medical service providers pressing to be included (some of them included high end facilities). By mid-2017 there allegations ofscandals unearthed in the scheme that touched on the teacher's union officials. More details on the discussion on the role of public private partnership (PPP) are continued in chapter 4. (see **The retired civil servant** below and **Shot and left for dead** in Chapter 2).

If one fears the cost of treatment either because they have no insurance or no out of pocket money to pay for the services they will not seek timely medical help. For something that might have been managed comfortably the patient might be brought in when it is too late, as an emergency or not at all. Some such have died on the operating table for what would likely have been cured if prompt medical attention had been receive (like the retired civil servant below).

The retired civil servant

MW, single mother, a 71 year old retired from a parastatal job was a patient with the typical issues of getting old but she also had a high blood pressure with chest pain on and off, had diabetes and a few complications. Her monthly bills (including physician services, hospital care, clinical services and prescription drugs) would come to almost Kshs 20,000 ($185). She was nolonger eligible corporate medical cover that her employer used to give her. She was unable to afford the medications even with an insurance card, which in any case was in arrears quite often. She barely managed to scrape together enough money for consultation and some tests. Once in a while her doctor recommended that she gets admitted but she chose to go home and sort out a few things.

The blood pressure went out of control and she suffered a stroke. Eventually she got admitted, already paralyzed on one side and unable to speak. This was how MW spent her last days.

[Shared with permission from significant other. Patients identity has been protected]

[5] Teachers Service Commission, TSC, Medical Scheme, *Aon Minet*. http://www.aon.com/kenya/products-services/teachers-service-commission/teachers-service-commission.js

According American College of Physicians (2000), the uninsured tend to be diagnosed at later stages of life threatening illnesses and on average are more seriously ill when hospitalized.

Kenya's increasing health care costs left it in position 120 out of 144 economies that were ranked in terms of access to medical services particularly in view of its transition towards middle-income status (Global Competitiveness Report, 2014/2015). It would be good to appreciate that no country can afford to spend unlimited resources on health care; there will be some rationing somehow. But having said so, it is a fair guess that there are no shortages of services for those who are willing to pay (either through pocket or insurance).

It has been shown that the higher the country's income, the greater its medical expenditures (Feldstein, 2011; p50). These findings were consistent in USA, UK, Japan, Australia, Norway, Germany, Canada, Denmark, Switzerland, Sweden, Italy, Austria, Netherlands, Belgium and France among others.

On an individual level, as people become wealthier, they preferred to spend more on health care to receive more or higher quality services. As incomes increase the amount spent on medical services increase proportionally (10% increase in income could lead to 10% increase in medical expenditure). Even though prices are a bit sensitive subject it was interesting that a 10% reduction in price of services led to about 2-10% increase in use of services although this varied depending on type of service.

These findings may or may not be so for Kenya, it is not possible to ascertain how much value Kenyans placed upon their health in terms of insurance. Less than 1% of the population was insured, a bigger portion being through the mandatory employer check off to NHIF.

This being so even when the rates used to be Kshs 150 per month (approximately 1.2US $) for the lowest contributors yet only few Kenyans subscribed. It had since risen to Kshs 500 per month (a cover of Kshs 6000 per year) with higher inflation hitting an all-time high at 11.5 percent. 1US$ exchanging at 106 Kshs in March 2017, it could be even harder to attract more.

Anecdotal evidence from a consumer perspective, it had been observed that even the 'best' arrangement to get a private medical insurance cover usually presented some difficulties when it came to accessing benefits.

Transitioning from being uninsured to an insured status was another challenge. Though the public health insurance has been available since 1966, only 20 per cent of Kenyans have access to some form of medical coverage according to World Bank. This was about 38,400,000 of 48 million Kenyans were excluded from quality health care coverage.

Policy documents did not always cater for the best consumer interests or apparently did not have them at heart. Many ordinary Kenya's admitted to a feeling of 'being duped'. It seemingly made as desperate as possible the disparate groups in their quest for wholistic inclusion into a medical policy, many just gave up.

Others relegated it to a temporary convenience to be considered in future when things - 'the economy' improved somehow. At any rate many felt illiterate in terms of the secrets of general insurance matters such that only a tip of the terms and conditions got to be known by the customer.

One such consumer felt that the waiting period was 'extortionate' to say the least, saying it was good to go into it with the 'eyes open'. Keeping up dated premiums was big headache leading to a good number of them not staying the course.

The consumer's power in accessing these was to be found among the elites, who even then for a good number of them the contracts were entered into on their behalf by their employee's benefits scheme. The ordinary citizens needed to be empowered to access decent affordable healthcare, to not just hope and pray for the best but to be assured of the same whenever and wherever they need it.

It would be a failure in imagination not to come up with what could work for as many if not everybody. May be social insurance would be the way to begin this long journey as seen below:

Diabetes

Juvenile onset diabetes and insulin dependent diabetes were once thought to be one condition. Adult onset diabetes and non-insulin dependent diabetes were thought to be another.

The current classifications are type 1 diabetes (autoimmune destruction of insulin producing beta cells) and type 2 diabetes (insulin resistance). Both occur both in children and adults, and type 2 can be insulin or non-insulin dependent.

Competitive Social insurance

FEP Medicaid

FEP Medicaid was open to Fountain Enterprises Programme (FEP) members, who numbered 206,000 by March 2017 with motto power of many. Bringing together investors from several walks of life spread out across the country.

Partnering with General Assurance Insurance (GA). Some of the salient features included in the cover were: eligibility 38 weeks to 80 years; beneficiary's child upto 25 years of age; Inpatient and outpatient; No age banding;

No age loaded premium; worldwide cover; biometric smartcard; budget and open plan; wide panel of service providers; countrywide access; psychiatric treatment; congenital and prematurity conditions; pre-existing/chronic/HIV/AIDS related conditions; one month waiting period for ailments (but 6 months for cancer related, 9 months for maternity); lodging facilities for parent accompanying child upto 10 years; evacuation – airlifting, road ambulance.

Auxiliary benefits included: inpatient dental; inpatient ophthalmology; cataract operation; last respect expenses benefits.

The lowest premium was Kshs 9500 per annum in 2017. Members who did not utilize their previous year's premiums had the benefit of having 20% of that converted into shareholding in an insurance company (in the making). In the word of Tai Medical Center's CEO this was an unbelievable package 'because this is our scheme, we can see how to make it affordable, available to our members when and where necessary, how to earn from it, what we can do to improve it…'

Tai Medical Centre an arm of the FEP group operated several high-end clinics and a cottage hospital in the country. The Tai Medical Hospital in Meru which opened in 2016 is a frontline provider also specializing in oncology treatment.

URI-AFYA

In 2017, Urithi Housing Cooperative Sacco and Urithi Premier Sacco partnered with Britam Afya to offer members microinsurance Uri-Afya. The membership then was 25,000 and 7,000 respectively. Through the memorandum of understanding members 18 years to 65 years old for Ksh 5800 per annum per member would be entitled to benefit inpatient cover of Ksh 200,000-300,000, Maternity cover, chronic diseases and pre-existing conditions, a personal accident cover of Ksh 100,000. It also included a last respect. In addition for Ksh 1400 -2000 per dependant (aged 1 month to 18-24 years) could be enjoined in the package.

Health coverage concerns have previously been about keeping the working class (organised, salaried, taxable employment) healthy and maintain their productivity (a benefit linked to work).

Moreover the formal working class represent a very small share of the total population in low and middle income countries; informal, non-salaried work was, and still remains, the situation for the majority of the population (WHO, 2010). Ironically the working class held strong position to defend their vested interests which might be substantial, even political but for the purpose of this discussion subverted to benefit a few.

With all due respect, this risked further widening inequities and increasing fragmentation in the already fragile health system. Focusing on how well a specific scheme performs, when it covers only a small part of the population, tells us little about how well the rest of the population is doing, it might even be detrimental to universal health coverage.

As a minimum we in this country needed a strong political commitment to universal health coverage among others. There was an urgent need to establish universal health coverage as a right to health care as entitlement for all citizens (a benefits linked to citizenship) as stipulated in the constitution. They will need to understand just like everyone else that universal health coverage is a right rather than a benefit of a salaried job. Also see **section 4.9.2** of this book on Universal Health Cover.

2.7.1 Role of Traditional Medicine

Not much will be covered in this section largely because this is an area the author had little exposure. However a few observations as we interrogate health systems in resource constrained settings would be in order.

Traditional medicine includes the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (The Health Bill, 2014).

The role of traditions in the health of Kenyans must be underscored here. A sizeable population are increasingly seeking care from herbalists and a minority from traditional healers (spiritual healers, bone setters etc.). For the typical African patient the overwhelming question was - Why did I fall sick? How does my state of health differ from that of others?



Pic: Apparently the African traditional herbalist was slowly being replaced by a more polished herbal practioner who did not hesitate to incorporate clinical as well as exotic products
(Photo courtesy of a personal communication a presentation in ethnomedicine by R. Rotich BBM 365: Health System Management, University of Kabianga)

These were concerns that the conventional medicine was ill prepared to deal with, yet quite well exploited by the traditional medicine practitioners (Fuglesang, 1982). Through their considerable social intelligence and knowledge of the community, analyses his patient's conduct and personal relationships they are able to accomplish what conventional medicine falls short.

Such are to be found in almost all societies and there is a lot we can emulate from and upgrade each other. However there was a perception from some opponents in what had come to be referred to as 'health care apartheid', alternative medicine was being promoted as *poor medicine for poor people* ignoring evidence based medicine which was reserved for the rich.

Herbalists were a common place and apparently this was a thriving venture commanding a fair clientele since time immemorial. However, there was a new breed of elite (briefcase) herbalists who were combining biological/medical science with herbal medicine (including exotic ones).

Anecdotal evidence shows that there was a deliberate move of many Kenyans easing up towards herbal therapy and dietary supplements that were said to prevent and control certain diseases. A popular mythical one-cure-all 'colon cleanser' whose main ingredient was extracted from *Aloe vera* was retailed by every other elite herbalist. They hyped it as good at 'kuosha damu' cleansing blood of toxins (in Kiswahili may be meant a detoxifier). It also was a cure for10 or so ailments.

Mwarubaine an extract from *Neem* tree (*arobaine* in Swahili means forty) was said to treat forty plus ailments. The lumping one-size-fit all model as practiced by many a herbalists could be scientifically challenged. Among other concerns was how this field adapted to changing evidence? (See **Diabetes** above).

The possibilities for traditional medicine are exponential. However, every other community in Kenya had its sets of herbal concoctions for different ailments depending on its culture and traditions. Though people were using herbs in Kenya, there have not been standard preparations.

Therefore, there was need to validate but not to crush traditional medicine. By documenting the medicinal plants, isolating, characterizing the bioactives compounds. We needed to add value to the practice by informing the herbalists what else the plants have, other uses we have discovered as scientists.

Endeavour to modernize their knowledge. Sometimes extracts contained hundreds of compounds some of which caused side effects. As scientists there was need to compensate the herbalists, make them part of the bioactive element patenting as part owners of the intellectual property rights since one was not allowed to patent a whole leaf or plant. This was also possible through copyrighting traditional knowledge and traditional cultural expression under suigenerics.

In the case of the traditional neurosurgeon who performed a craniotomy under a tree somewhere in Elgeyo Marakwet County, who was accountable in case something went wrong in the process and harm came to the patient? Would we sustain a civil case? Perhaps only a criminal case. The Ministry of Culture but not the Ministry of Health regulated their registration and perhaps their practice. What was the framework for regulating their practice? They needed to be involved in formulating such a framework.

One media house[8] on 12th June 2017 conducted dummy voting to find out the health seeking behavouir of Nakuru town residents. The findings were as follows: *prayers 9; public hospital 101; private hospital 62; self medication 12; herbs 23, spoiled votes 3*. Meaning there was some good faith among many Kenyans on traditional medicine although some of them used them covertly. Many herbalists did not wish to share about their secret herb(s).

The fairly popular ones come from conservative communities like the Ogieks of Mau East forest. In the absence of records, researches interacting with them had to make the best of 'unreliable' recall memory. This was a fair comment in that the same could be said about many entrepreneur researchers who were unwilling to reveal all what they had discovered and done.

The Muiri tree has almost become extinct hundreds of kilometers around. Identified as *Prunus africanus* (botanical name); *Muiri* (in Kikuyu); *Kinyukwet* (in Tugen); *Olkojuik* (in Maasai) among others.

A good example of an ethnomedicine practitioner is Gugu-tabibu (grandma herbalist) Irene Toroitich[9] from Keiyo Marakwet County. She claims that she has treatment for cancers, epilepsy, arthritis, ulcersamong others. Her clients come far and wide. A number of patients who have had treatment with chemotherapy before were apparently doing well on Gugu's herbs.

The Muiri story

In the late seventies and early eighties, some ridges overlooking Subukia valley spruced with vegetation, rivers like a legendary *Nduthi* roared down the gorges of Edgewood. It had a couple of bridges downstream. There centuries old muiri trees flourished. They grew in diameter, towered 40 plus metres. The impressive canopy provided speading crowns. The residents had age old usage for its bark. It was a cure for all manner of ailments: fevers, wound dressing, sexually transmitted illnesses, purgative, appetizer, stomach pains etc. (Wikipedia)

This was before someone got some better use for it. Cure for benign prostatic hypertrophy (BPH), cancers etc. The bark extract *pygeum* could not sustain export demands. The brokers, who it was alleged included a renowned 'conservationist' descended on the ridges, cut down the whole tree , stripped the bark, and gave the local women the wood for fire. No one thought of harvesting only the bio-renewable parts of the tree that could not be exhausted.

The bushes were cleared for other uses too. Dried tree stumps could nolonger meet the demand for charcoal. It went quiet except for tractors that ploughed the ridges; Nduthi River was now a seasonal river. ('Nduthi' river had acquired a functional meaning from lister engine water pumps that suctioned dry water pockets to irrigate rose flowers, and injected effluent in equal measure downstream). Local women now worked in the flower farms.



One of Gugu's client made this comment '*Sio kama chemo-, ya Gugu haina side effects',* translated - unlike chemotherapy, grandma herbalist's treatment had fewer side effects. She had both experiences with conventional and alternative therapies and was looking fine. Next door in Mzee Komen Cheptoo[10] *daktari mpasuaji* (Swahili for surgeon) performs craniotomy under a tree and he had a number of patients.

There is also danger that some of these plants harvested from these arid and semi-arid lands (ASAL) are becoming extinct especially where roots are used. There is need to document them and as much as possible look for ways of conserving or propagating them.

[8]KTN News, *Kivumbi 2017* 12th June 2017 - Dummy voting 'where do you turn to when you need health care?'

[9]KTN Leo Wikendi; *kadhia ya saratani*, 08 Feb, 2015 7.30 Hrs.

There has been collaboration between some element of traditional and contemporary medicine. For example, in an effort to fight lifestyle- related conditions and non-communicable diseases, by utilizing a sacred horn 'Pembe' that would be handed over from one county to another by nominated beauties 'Malkia' for queen in a special ceremony[11]. Recently was between the people of Vihiga and Taita Taveta Counties.



Pic: Scramble for meagre resources is a reality in many health care facilities, this might give the people an option to seek alternative medicine for (Picture used with permission: Community Eye Health *Update 6*)

Traditional medicine was not without its dose of other problems. There was fear that diseases like Hepatitis 'B' could be spread by sharing traditional cutting tools. NTV news on Saturday 17th September 2016 run such an item showing increased prevalence of Hepatitis in Baringo County mainly due to traditional beliefs in healers.

Kenya had also made strides in complementary and alternative medicine. Areas like homeopathy, acupuncture, laser etc. had found their place in the Kenyan health sector. In 2007, the Kenya School of Integrated Medicine sponsored by among others - The 4Kenya Foundation, Homeopathy Action Trust opened its doors. It has been offering 3 year Diploma in Homeopathy.

[10] Citizen Nipashe, *daktari mpasuaji,* 05th April, 2015 7.30Hrs

[11] NTV *kuna Jambo*, Lolani Kalu; 04 Jan, 2014 19.30 Hrs ntv.nation.co.ke/news2/topheadlines…

2.7.2 Role of faith in health care

The role of faith and health care cannot be overlooked. Infact *The Lancet*, a world leading journal of medicine and global health in 2015 devoted a whole edition to the role of faith in health care. This was one of its conclusions by Summerskill & Horton:

> 'Faith-based organisations deliver a substantial volume of health care, and their common visions of stewardship, inclusiveness, dignity, and justice make many such organisations ideally suited as key partners for delivering the post-2015 Sustainable Development Goals.'

Kenyans were generally inclined to religious faith in matters health, life and death. Religious or spiritual leaders were often the first people individuals turned to in times of crisis, and sickness was one of them. They were reachable and approachable. It was unfortunate that many elected leaders were known never to pick calls from 'new', unfamiliar callers. How on earth was the ordinary Kenyan ever going to get to them?

Even in hard to reach and remote places which were a long way from health facilities there were churches, mosques etc. By Mid 2017 there were 300,000 registered churches in Kenya as per the Registrar of Societies. These were more than the number of schools, health facilities etc. However, in March 2018 NHIF opted to engage a section of the youth to reach out to their communities to popularize the forthcoming universal health cover and recruit new members into NHIF scheme.

This was a realistic network that could be tapped. If there was a natural disaster, communities could be mobilized to respond through the churches. In African settings, people always go in and out of each other's homes. The pastor was a respectable visitor and opinion leader in the day today lives of people.

Helping people change their behaviours very often meant offering them an opportunity to change some of their beliefs. Teach them to live their faith in a very practical way. Some people believed that diseases were caused by evil spirits and it was necessary to inform them that doctors are one of the ways God brings healing and recovery.Impress upon them that seeking medical help did not show a lack of faith in God. That they could seek help from God as well as go for appropriate treatment – not instead of doing so. People want to share any joy or sadness in their lives with the church. The need for social support as found in the church was very important. Faith in health care emphasized on showing compassion, the need to treat the human being and not just the disease. 'Every other person did what the pastor said': wash your hands, family planning, immunizations etc. The Catholic Church for example did not support non-natural methods of family planning (MaterCare International medical news, February, 2015) They expressed misgivings about the mass tetanus vaccination to all women of reproductive age of 2013,'…Campaign is not about eradicating neonatal tetanus but a well-coordinated forceful population control mass sterilization exercise using a proven fertility regulating vaccine'. Even as Oral polio vaccine was being given in a series of campaigns reports from WHO in mid-July 2018 that the vaccine was linked to new polio outbreak. No less than the *Director of Polio Eradication Programme* Michel Zaffran told the CNN. What will an ordinary Kenyan make of such disclosures?

Some readers from Kenya might remember around July 2017 the purported resurrection of a lady who had died of illness *Mama Rosa, amefufuka, anatambea, it is well, mungu wetu, mungu wa nabii, amefufua.* Paraphrased - a lady by name Rosa is back to life, is up and about, it is well because the God of the Prophet has done it.

Many a health care provider felt that they chose or were called into the profession in which they could help people. They feel called to provide the care, resources and inspiration to alleviate human suffering. Often feeling that even if they did not always

receive payment they would be richly rewarded in other ways if they cared for patients in a loving way.

Many with such a calling volunteered to go to places where nobody else wants to go and run a health care model on a missionary basis. Mostly in far to reach, solitary places. A good number of them go-native and become part and parcel of the communities they treat. Helping find simple solutions with excellent results based on available resources. They have been known to keep journals that have revolutionized the way medicine was practiced.

2.7.3 Impostors in practice

In diverse regions of this country, it was common to get that illegal clinics, pharmacies, laboratories, and even hospitals operated. Some were unlicensed while others had all the necessary documentation but were operated by unqualified staff. Others operated under a chain 'cover' from the genuinely licensed ones. In these categories there were those that were operated by medical staff on locum basis outside working hours.

Quacks set themselves up in urban as well as rural areas in equal measure. The informal settlements - slums had a big share of such back street 'kiosks' as they were popularly referred to by medics. They conveniently opened and closed as need be to escape being netted during the (ir) regular rounding up by the regulatory boards.

A few more daring ones were fully fledged outfits which operated freely with least suspicion. A number of them had set out as herbal clinics but it was alleged they actually were compounding conventional medicines and selling them as alternative therapies.

In some instances it was alleged that money changed hands freely between these entrepreneurs' practitioners and the respective inspectorates. Raiding on illegal clinics pharmacies and labs then became a window dressing affair. Business 'as usual' resumed in no time.

The outright daring ones posing as qualified staff somehow made their way into mainstream health system and remained there for as long as it took to get them unmasked. Consider the following **Fakes thrive** which appeared in the media[12] in May 2017.

[12] The Standard 25th May 2017, Law too soft to eliminate fakes…

Fakes thrive

RKM, a 28year old impostors doctor had been practicing for over 2 years. He had managed to rise to the rank of medical superintendent of a sub county hospital. During that period records indicated that he had done at least eight successful operations.

The University of Nairobi where he claimed to have studied medicine denied he was ever their student [his name was neither found in their registry nor in their Bachelor of Medicine and Surgery (MBChB) graduation lists]. At the headquarters Ministry of Health, his file was apparently a'healthy one'. He was in possession of all signed 'necessary documents' including a letter that indicated that he had completed his internship in one of Kenya's well known mission hospitals.

He was arrested as he tried to renew his license with Kenya Medical Practitioners & Dentists' Board (KMPDB). He was later arraigned in court for forgery of academic documents and posing as a medical doctor. Section 22 of the KMPDB Act seemed not to have enough teeth to eliminate these fakes. Actually it was too soft. Ksh 10,000 or a jail term not exceeding 12 months imprisonment or both. The lenient fine most of those caught could afford to pay. Those who use the title 'doctor' without qualification were fined Ksh 10,000 or a jail term not exceeding 2 years or both. Quite Easily Done! It was said that some paid the fine or served the sentence and resumed the illegal dangerous business. It would have been necessary to enjoin those who 'cover' them or supplied them with medicines etc. into the suite.

One or two had the guts to seek for an elected post in the general election. They were not the only ones who did so. It was still possible for some people who had been adversely mentioned in corruption and such other vices (some available as public evidence and the rest as court evidence) to be overwhelmingly voted during nominations and general elections. It was unfortunate that integrity filters could flop as several red card holders got cleared to vie on a regular basis. A plethora of institutions that should have reined on these vices failed or did too little too late. For example, the legal process was time consuming and The Constitution Chapter 6 (on Integrity) as itis did not help either.

2.8 Health Care Workforce

Going by a report entitled "Where Is Your Doctor?" (2013), Embu, Mombasa, Nyeri, Uasin Gishu and Isiolo counties had the most favourable health worker-population ratio. The report also ranked among the top five counties. According to the report, there was at least one health worker for 197 people in Embu County, one health staff for every 227 people in Mombasa County and one health employee for every 238 people in Nyeri County.

The survey funded by *Hivos* shows the skewed distribution of medical professionals has denied Kenyans an equal chance to quality healthcare. The study ranked Mandera, Turkana and Kisii among counties with the worst distribution of health workers. In Mandera, for instance, there is only one health worker for every 2,456 people, while in Turkana and Kisii counties the ratio is 1:2,148 and 1:1,930 respectively. No county so far met the required ratio.

The most pressing problem for the health care workforce in Kenya is the drastically unequal distribution of workers, by urban/rural areas, by regions, and by level of care. According to Health Sector Assessment (HSA) Report 2010 by Luoma *et al.,* (2010), the Ministries of Health continue to spend a large portion of their allocation, 71 percent, on recurrent costs including salaries of which approximately 25 percent of the human

resource budget for the entire public sector is taken up by the two referral hospitals (namely Kenyatta National Hospital & Moi Teaching & Referral Hospital).

According to the Hivos study (2013), the distribution of health workers in Kajiado and Narok is also poor. In Kajiado, one health worker was expected to attend to 1,520 patients while in Narok the ratio was 1:1,373. No county had so far met the required health staffing levels according to workload indicators of staffing needs (WISN). For many a healthcare provider in these settings, a high volume of complex patients may turn an 8-hour day into a 12-hour day with no extra pay for work hours.

According to the World Health Organisation (WHO), availability of skilled and motivated health workers in sufficient numbers is critical in attaining better healthcare outcomes. It had also emerged the doctor-patient ratio has widened in the past three years, an indication that the number of doctors entering and staying in the public health sector has been outpaced by population growth. In 2017 there were about 5700 doctors in Kenya .

The Kenya Medical Practitioners Dentists Union attributes the low retention of doctors in the public sector to poor remunerations and poor working conditions. The government itself in late 2011 admitted that up to three quarters of doctors joining public hospitals after graduation will have left these hospitals in three years' time[13].

By end of 2011, Kenya had a doctor-population ratio of one doctor to 17,000, but a recent report by the Ministry of Health report suggests that the country had one medical officer for every 20,000 people. According to: Kenya Service Availability and Readiness Assessment Mapping (SARAM) also showed that there was only one registered clinical officer for every 10,000 people and a nurse for every 3,333 people (WHO, 2013).

According to chairman Kenya Medical Practitioners, Pharmacists and Dentists union (KMPPDU) Dr Samuel Oroko, in 2014 alone 1800 doctors left public service to join private practice. The main reason cited during this season was the bumpy take off that characterized the revolutionized health care services; there was reported harassment of health care providers by local leaders including Members of County Assemblies (MCAs) who forcefully wanted to run facilities in their various wards.

2.9.1 An advocacy approach

An advocacy approach involves influencing powerful decision makers to bring about change. It can be a long process because it often involves changing people's views. Communities and individuals, who until recently were expected to be passive recipients of services, were now expected to become engaged participants. According to Martin and Singer (2003) to change communities from being passive participants to active participants in the priority setting process, there was a need for them to be empowered to demand for publicity, appeal, relevance and strong leadership in the
priority setting process.

Thus, redefining the appeals mechanism and expanding the opportunities for the communities to contribute relevant considerations to each decision and specifying the ground for appeal would help improve the quality of the decision-making process.

Advocacy plays a significant role in the modern politics of inclusion. It seeks to cause benefit (usually long term) to be accrued to individuals and groups where possibly none

[13] www.uneca.org/adf2000/abuja%20declaration.htm. Accessed 2 January 2015.

would have been in the absence of the advocacy effort. It had been shown to bring to or restore a sense of significance or relevance to an issue that was overlooked (Wikipedia).

Advocacy was also tied to a method of problem solving or resolution and driving systems change. Professionals, associations etc. have a key role of taking up the role of advocacy for their own cause or that of others (usually less powerful or less fortunate) because they can generate energy and flow in articulating issues.

2.9.2 Policy Issue

The following policy issue dated 25/07/2015 was written by this author and posted to:

Clerk of the Senate, Kenya's Eleventh Parliament, The Senate Standing Committee on Health. Email: senatebills@parliament.go.ke

Subject: *Cancer Prevention& Control (Amendment) Bill, 2015; HIV AIDS Prevention, (Amendment) Bill, 2015; National Insurance Fund (Amendment) Bill, 2015*

Response to Requirement of Public Hearings/Receipt of Memoranda: *Proposed Policy on Involvement of Men in Maternal and Neonatal Child Health, HIV/AIDS Prevention, National Insurance Fund and Cancer Prevention & Control in Kenya.*

Involvement of Men in Maternal and Neonatal Child Health Kenya

Background of maternal neonatal system

Issues of the new-born cannot be addressed separately as they were intrinsically entwined with pregnancy, labour, delivery and postpartum care. Thus there was a need to integrate the maternal, neonatal and child Health (MNCH). Kenya made significant strides in reduction of mortality rates in maternal, neonatal and children in the last five years but there were still concerns emanating from the results of the Kenya Demographic Health Surveys (KDHS). However, maternal and newborn health indicators in Kenya had generally shown very marginal improvement over the years.

Infant, under five mortality, declined from 74 to 52 per 1000 and infant mortality from 52 to 39 per 1,000 compared to 2009. This was according to KDHS released in January 2016. It also indicated a 96% of women had a live birth in the last five years. The maternal mortality dropped from 488/100,000 in 2009 to 362/100,000 in 2016. 58% of women attended 4 or more antenatal visits during pregnancy up from 47%. (However, the Meteitei case study done in 2015 utilized the 2013 statistics).

There was a need for nurses and midwives to get men to buy into MNCH as key stakeholders to resource mobilize for identified priority actions (as will be described in the policy issue). The purpose being to improve maternal and new-born survival. Home grown solutions like Meteitei's case would in some way show case that with support such efforts could be customized across the country (Kamau *et al.,* 2017).

However, this needed a well-coordinated front. By sending a policy issue to The Senate, the upper house followed with a petition to advocate for laws and policies to scale up male involvement in MNCH. Coincidentally, The Senate had sent out a requirement for

public hearing and memorandum in a related area. This policy issue is largely an amplified version of this attempt; the response so far was encouraging.

Description of the issue addressed by the policy

> The scenario: Within the rural context, not delivering at the health facility may mean the difference between life and death for both the mother and the neonate. Men have tended to keep off 'the women business' only to be called in when the attending women have tried everything and anything conceivable to help the woman in labour. Involvement of the man to is key to do checks, the arising needs, rearrange priorities to meet the changing demands of care or for referral. This is Meteitei, a mountainous region of Tinderet-Nandi escarpment, Rift Valley Province of Kenya. Here, about women 92% attended ANC at least once during pregnancy but skilled attendant delivery (SAD) was 6.8%, compared to the national average SAD of 44% (KDHS, 2008-09). It had Maternal Mortality Rate (MMR) of 500 per 100,000 by 2013 report.

Most maternal and neonatal deaths are caused by a few conditions, most of which are preventable with available interventions integrally related to the availability and quality of essential and emergency child birth services. Effective interventions to reduce maternal deaths, stillbirths and newborn and child deaths reach less than half the pregnant women, mothers, newborns and children who need them.

Problem statement: You are a policy analyst/developer. Your team has been asked to develop a policy to supplement government effort to reduce maternal infant mortality by working with male champions in Maternal Neonatal Child Health (MNCH).

During a presentation by Dr. Jean Kagia, Obstetrician Gynaecologist from Kenya presented on improving access to maternal health in Kenya to *International Symposium on Maternal Health* Dublin, Ireland, 2012 (take help of tutorial onYouTube).

One specific policy-relevant problem that was discussed as part of the meeting was a most urgent need to involve men in maternal and neonatal child. This called for developing a policy which would have a multifaceted approach:

*Reduction of maternal & child mortality and morbidity,

* Elimination of mother to child transmission of HIV and
*Increase uptake of family planning.

The huge difference in the risk of maternal deaths between the developing and developed countries was thought to be due to differences in access and use of maternal health care services (WHO, 2003; UN, 2005).

Counterargument: Some other people might have picked it up and it's already happening. Or who is behind it, it's a foreign idea, a foreign donor perhaps?

Background: Maternal mortality rates (MMR) MMR levels in Kenya have remained unacceptablyhigh at 510 per 100,000 live births (UNPF, 2015), with some regions like Lamu County reporting MMRs of over 1000 /100 000 live births. These are disturbing facts. In the words of AMREF[14] *Lamu needs us to do more*.

[14] Amref.org/info-hub video on AMREF's Lamu Maternal Newborn& Child Health Project.

Demographic and health survey 2014 estimated that 2 percent of women of reproductive age or 1 in 67 will have maternal death in Kenya. These figures translate to a lifetime risk for maternal death in Kenya of 1 in 39 according to other sources. When this was compared to developed nations such as North America, MMR was 11/100,000 live births with a lifetime risk for maternal death of 1 in 3,800 (Mangeni *et al.,* 2013; World Vision 2014; Mailu, 2012).

*Many new-borns died in Kenya in the first month of life (26 per 1000 live births). In 2012, 100,000 died before their 1st birthday. Everyday 15 mothers and over 290 children below age of 5 died largely from childhood preventable diseases, pregnancy, birth complications and HIV and AIDS. (Carrma 2013; *K4* Maternal, Neonatal and Child Health, *n.d*).

Counterargument: Some opposed say our context is different and figures can lie, that things have improved in last 4 years.

> *'There are virtually no children born with HIV in the US, Europe, or other western countries, the vast majority of affected children are born in sub-Saharan Africa'- Born free*

* Nationally the prevalence HIV was 6.1% (women 6.9% and 4.4% men) (UNAIDS, 2013). Rate of new infection in 2016 was 70,000 with 43per cent being people between 15 and 24 years (NASCOP). Hence the need to prevent mother to child transmission which could only be achieved through access to antenatal clinics and skilled hospital delivery.

According to Born Free (*n.d),* more than 90% of new HIV infections in children resulted from mother to child transmission during pregnancy, childbirth, or breastfeeding. It has been seen that it is possible for some countries to significantly accelerate their paths toward virtual elimination.

Counterargument: That achieving a beyond zero figures needs to be looked at as long term goal not possible in near future.

The Three Delays

Ask men to help us deal with the 3 delays decisively; these delays contribute to maternal/neonatal morbidity and mortality:

1. **Delay in deciding** to seek appropriate care. This could be due to: socio-cultural barriers, failure to recognize danger signs, failure to perceive severity of illness, and cost considerations

2. **Delay in reaching** an appropriate health care facility. This is due to: long distance to a facility, poor condition of roads - rocky steep, rivers overflow during the rainy season, lack of transportation and cost considerations

3. **Delay in receiving** adequate emergency care at the facility. This may be due to: Shortage of staff, supplies and basic equipment; unskilled personnel, user fees among others

The main killers being pregnancy, unsafe abortion, childbirth which could lead to complications such as severe bleeding, infections etc.

Meteitei case study

Table 1: Meteitei Catchment Population Projections for 2014 MCH/RH Clinic

Population	No.
Catchment population	25288
Target Population < 1 year old	966
Monthly target	80
Adolescents	3783
Women of Reproductive age	6679
Pregnant women	1138
Children < 5years old	4552

(*Source-Health records Meteitei SD Hospital, 2013*)

- Between Dec. 2011 – Sept. 2012 only 5 (0.5%) out of 1063 PMCT- tested women had their male partners receive HIV counselling and testing.

- Between Dec. 2012 – Sept. 2013, 181 (17%) out of 1060 PMCT- tested women had their male partners receive HIV counselling and testing. This was a great improvement.

The rest (1060 minus 181= 879) the partner did not come, only the women were available for counselling & testing. Only one couple who tested HIV+ was linked to care and treatment.

Some of the factors that might have contributed to high maternal child mortality in rural Meteitei include:

D Poor sensitization of women to the importance of delivery by a skilled attendant, the highly valued social role played by traditional birth attendants (TBAs) in communities,

D Perception that the health facility as a harsh setting for childbirth.

D Other important barriers include lack of means of transport to the health facilities, hostile terrain, cost of transport and delivery,

D Fast progression of labour,

D Some women did not think facility attendance was necessary due to previous uneventful home delivery and therefore prefer home delivery.

Cap 253 The Reproductive Health Care Bill, 2014 Bill seeks to deal with the issue of inadequate facilities at county government hospitals, especially in terms of emergency services including but not limited to ambulance services and equipment for intensive care services and gynaecological services as well. "maternal care" includes health care of a woman during pregnancy, childbirth and forty two days after birth. it recognizes the role of the partner (spouse of the opposite sex).
Counterargument: The bill is sponsored by a woman senator, it has many an 'anti-men' provisions, requires lots of amendment before it can become law

Policy Goal

Clearly men have an important place in MNCH. This policy therefore seeks to harness the potential role that men can play in promoting the health of the mother and child and the importance of strengthening the interface between men and health services for the sake of the mother and child.

Involvement of men in MNCH services would be critical because HIV incidences are still high despite available ways of preventing the disease. We are mostly left with changing our behaviour patterns.

Counterargument: Men are already involved in a big way.

Rationale

The rationales for emphasizing male men involvement in MNCH rests in its benefits in preventing MMR and neonatal infant child mortality include:

- Identifying barriers that hinder the uptake of ANC, delivery in hospital, and family planning services from male perspective. Considering men been have side- lined for so long and we all know that they play a huge role in determining if the mothers come to the clinic or not.

- It is especially important to understand ways for male involvement in helping to achieve zero mother to child HIV transmission, improve the effectiveness of PMTCT service delivery models.

- Men control about 70% of the family expenditure with women and other members controlling about 25% (Amref BOMA. *n.d*). In our low income setting men aren't involved in reproductive health issues. Women health information and messages needed to be culturally sensitive.

- Men are gate keepers of culture and society values, some of which still contain and accept several harmful practices that have very negative effects on women

and their reproductive health rights. These practices include early or child marriages, female genital cutting or mutilation and nutritional taboos that affect the health of girls and women. Counterargument: women are their own worst enemies.

- Reproductive health services are important entry points for most HIV and AIDS services, such as prevention of mother-to-child transmission (PMTCT), voluntary counselling and testing (VCT) for HIV and AIDS and antiretroviral therapy (ART) interventions (K4 MNCH).

- There are many claims trying to ascertain why HIV/AIDS prevalence was on rise especially to married couples.

Men entry into the MNCH system

-Home (husband, spouse, partner, brother, 'sponsor', teenage/young adult, boy child). Whether in or out of the family setting.

-Community (friend, neighbour, CHV, CHW, church, schools, place of work, farms, CBOs e.g. Chama cha Wazee, Manpower)

-Health facility (Maternity, PMCT, VCT, MCNH clinic)

-Sub-County (advocacy, leaders), NGOs

-County (advocacy, leaders, resource allocation, ordinances making, supporting affirmative action of 2/3 gender representation, make maternal health a standing agenda)

-National (advocacy, legislation, supporting the affirmative action of 2/3 gender representation, a commitment of resources for maternal and new-born health, make maternal health a standing agenda).

-Sponsor motions to improve access to maternal neonatal child health care at County Assembly and National Assembly and The Senate.

Foundational principles

- Encourage the involvement of men in programme interventions as decision makers, partners and/or health service providers.

- At community level through men's groups, religious organisations and other community mobilisation structures.

- There is need to identify the areas and levels of involvement and also being specific on what males: are they husbands, boyfriends, sons, fathers or just any man around?

- Encouraging men to use a Rights approach, citing The constitution of Kenya (2010), working with local leaders and government - advocacy to hold service

providers accountable, interrogating the service charters, memorandum of understanding (MOUs) where there are gaps in health provision,

- Volunteering cannot be taken for granted or may not be a common concept so incentives to foster active participation

Counterargument: The African culture accepts volunteerism but then the community health volunteers have families to feed so need to be paid.

- Targeting men at all levels but especially couples who are expecting a child,
- Taking a multi sector approach e.g. Microcredit to ensure domestic economic sustainability
- Ensuring that organisations share their vision with the community to own projects.
- The use of the national media (radio, television, newspapers) as well as local community groups to create awareness and sensitise the general population to MNCH care and harmful practices. Men listen to the radio a lot more than woman.
- Helping men to identify other men who are into drinking, gender based violence, neglecting their families
- Identify and create rapport with Boma heads where community units will be established/strengthened. The Boma model has strengthened organisational systems within community (Amref BOMA, *n.d*).
- Engaging the community with respect,
- Connecting with deep-rooted community structures to ensure sustainability and encourage ongoing grass root involvement of gatekeepers even as we advocate for safe motherhood (Amref BOMA, *n.d*)

Counterargument: Some traditions continue being passed from mother to daughter, 'You need to learn how to deliver a baby, because some day you will have to help another woman give birth'

- Addressing reproductive health and family planning needs of the male

Counterargument: Most of the available FP methods involve the woman to use not the man. Again, there are sentiments that prevention of mother to child transmission to a large extent concerns the mother and not the father. Since it involves exclusive breast feeding, C/s birth, mother taking ARVs prophylactically during pregnancy.

- Policies of health care establishments and attitudes of service providers serve as barriers to greater involvement of men even when they accompany women to health facilities
- Provide male-friendly services that encourage men to accompany their female partners to health facilities and to seek out and use services themselves. Couples who attend clinic are given first priority on the queue.

Counterargument: MCH clinic is for women

- Addressing concerns of men sexual relationships and have great potential for leading the way in promoting sexual health and efforts to prevent sexually transmitted infections and HIV transmission.

- Encouraging men (those who can) to become individual birth partners of choice during labour.

  Counterargument: This cannot happen in the African culture, you cannot expect men in the labour ward. A safe delivery doesn't mean one divorced from people's culture. Whoever else (not necessarily men) the community wished to be present during delivery should be encouraged to stay on.

- Advocate for men as clients, partners and agents in promoting the uptake of HIV services at family and community level.

- Call to action for men to actively engage in promotion of maternal and new-born health to increase uptake and utilisation of services (Office of The Ist Lady, *n.d.*).

- Training of community volunteers, retention of as many CHWs as possible volunteering in the program and capacity building.

- Vision of starting a 40 bed home for mothers who are expectant to be near the health facility whenever they might have difficulties accessing care.

  Counterargument: Some women might misuse this chance to run away from home, the hostel will be turned into a hospital ward. It was too early to require women who had entered the 3rd trimester to report for accommodation in the maternity waiting home.

Elements of men entry into the MNCH system

- MNCH recognizes the potential role that men play in promoting the health of the mother and child.

- The importance of strengthening the interface between men and health services for the sake of the mother and child.

- Promoting community awareness on in/fertility (increase access to proper investigation and management of infertile individuals and couples).

- Male involvement in Dialogue Days and other stakeholder forums to reinforce key messages: make maternal health a standing agenda.

- The man helps the woman realize the importance of focussed antenatal care: Early preparation for safe delivery (physiological readiness of the mother, to encompass psychological, intellectual, social and financial preparedness) in order to beat the odds and rise above the contextual challenges.
- By making multiple services available in the same location on a single visit, maximizing on each opportunity for a greater impact. Adopt "One-Stop Shop" approach in the target facility to enable clients' access health services.
- Men accounting for paternal leave to 'shower' care the mother and new-born

- Target men wherever they are with messages on antenatal, hospital delivery,

postnatal visits, child welfare, child nutrition and family planning.

D Packaging and repackaging services: integrating family planning with other reproductive health services - postpartum family planning, post abortion contraception, HIV and AIDS services, screening for prevention and control of cancers of reproductive organs in both women and men - namely cancer of the cervix, breast cancer and prostate cancer.

Counterargument: Men cannot afford to wait.

D The role of the father in supporting breastfeeding; address common myths and misconceptions about breastfeeding. Messaging related to breastfeeding with HIV/AIDS. Men to promote, protect and support mothers to exclusively breastfeed during their infant's first six months. To provide the best local foods from six months through two years of age to help their child grow, develop and survive.

D Sensitize the men on dangers of gender-based violence: physical and sexual abuse and violence, including rape. Are violations of the right to be free from inhumane and degrading treatment? Long-term negative health impacts, including severe psychological; emotional; and medical consequences, such as the increased risk of unintended pregnancy and sexually transmitted infections, including HIV.

D Men to come up with strategies for those women living in inaccessible mountainous areas e.g. a mothers' hostel so that they can be near the hospital as their estimated date of delivery nears. A proposal would be sent to Nandi County government.

D Facilitate pre-payment schemes: medical insurance, transport to a referral facility through fathers' clubs or other community mechanisms.

Counterargument: Maternity care is free in public hospitals, but the insurance covers the family in all other times.

D Encourage corporate social responsibility. Send a proposal to George Williamson Tea Company (a major employer in the region) requesting them to equip maternity wing of Meteitei sub-county Hospital with delivery sets, caesarean sets, infant resuscitaires, and delivery beds et cetera.

D Establishing partnership with students and faculty who bring students for rural health attachment in the region to identify an intervention project, become alumni's for the community and plan for outreach.

an antenatal mother who is HIV negative turns positive 6weeks postnatally during one of the rapid response initiative campaigns.

We could conclude that the spouse was HIV positive since they were not tested together or may have been involved in unsafe sex and thus transmitted to the spouse (pregnant woman).

D Procure off-road vehicles, trail motorbikes and ambulance to be stationed, 'Beyond zero' campaign truck to be going for outreach in hard to reach zones.

D The traditional birth attendant's role would be phased out gradually when we have eased the shortage of staff able to go and assist the women to deliver in their homes

Counterargument: TBA's play a very important role, culturally acceptable, are friendly, available any time. They have saved many a situation.

D Work with community implementers to record pregnancies and births in the

D Emphasis for regular screening for cancer of breast (clinical and self), prostate cancers (clinical and Prostatic Surface Antigen (PSA) tests.

D Obstetrics fistula identification and care

D Sexual health and marital counselling.

D Routine community outreach activities, including community health worker home visits, community dialogue sessions, mother support groups, and health action days.

D Brochures, and posters to support integration efforts, and serve to complement existing community-level reproductive health and nutrition materials

Monitoring

D On a monthly basis hold men focus group discussions to note emerging issues and progress made.

D The number of men groups showcasing their initiatives concerning maternal health at county and national level to exchange best practices.

D Acknowledge when the outcome are less than expected.

D Utilize evidence based tools for probing any such deaths. Modalities on how the membership of the probe teams would be constituted for each facility. Probe team would meet not later than 1 day after such an incident.

D Correct negative outcomes quickly

> *Percentage of men who accompanied their spouse(s) or partner(s) to at least one antenatal care (ANC) visit:(# of men who accompanied their partner to an ANC visit/ Total # of women who report their partner had an antenatal visit) x 100.*

D Modify the process to avoid further negative outcomes

D Service charters to note undue delays in waiting time at the facilities

D Submitting regular performance reports to key administrators and other stakeholders.

D Examples of measurement and monitoring

D The number of babies immunized (even out of hospital deliveries) within 2 weeks were brought for immunization. Number of deliveries per month within the health facility

D Counterargument: these are gender roles that men are not equipped to play

Picture: Men need to give a hand in maternal health



(Picture courtesy of *Born Free* .Used with permission)

Discussion

The policy issue presented the position of maternal and child health and the involvement of males at Meteitei sub-County. The path they had opted to take largely out of their own initiative. The difference it had made in improving maternal, new-born survival suggested that such effort could be replicated throughout the country.

Reducing these mortalities could be accelerated in perhaps less than half it had taken since there were now deliberate efforts by various state and non-state actors. Creating policies and laws that supported them should not be taken for granted thus enlightening the leaders was a necessary step. An advocacy approach was found to be one of the effective ways of reaching out. A policy issue to lobby The Senate was a necessary step. It contrasted the diverse arguments and counterarguments.

Summary

Many male partners would tend to isolate themselves when it reaches a time when a woman is pregnant and also when she gives birth. Ideally couples should test together at antenatal clinic and retest after every three months in case of any positive results intervention would be carried out. Indeed male involvement research is relevant, timely and can provide a few answers to reduce infant/child and maternal mortality and eventually translate to stronger families, a healthier and productive/prosperous nation.

With men incorporated Meteitei region showcased that the death of another mother, neonate or child was not excusable. Taking into account the difficult context which includes poverty, lack of access roads to the villages, cultural challenges and personal preferences relating to maternal and child health, the man has considerable influence on the process and outcome of care.

The original policy issue was submitted by this author to The Senate, Kenya as a response to requirement by clerk of The Senate to members of the public to submit memorandums in the *Prevention and control of HIVAIDS amendment bill 2015*.

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CHAPTER 3

Aspirations of Kenyans on Their Right to Access Quality HealthCare

Overview

The world, donors, advocacy groups, the government, leaders and Kenyans in general had placed higher demands and more ambitious hopes for health systems than ever before. Without exception this author believes that no country had developed without improved health care of its citizens. The Constitution of Kenya provides for the Bill of Rights which includes the right of Kenyans to access quality health care services taking into account the constraints imposed by history and previous decisions - whether they were good or bad (path dependency).

A scale up for better health is critical in accelerating attainment of health impact goals as defined in the Kenya Health Policy Framework (KHP) 2014-2030 as contributing to the economic development under Vision 2030 social pillar that creats a healthy skilled workforce. The goal of KHP was the attainment of the highest standard of care in a manner responsive to the needs of Kenyans.

Observing quality from the patient's perspective is of paramount importance for making the service more responsive to patients. There is need to address the citizens' expectations on the right to the highest attainable standards of health, including reproductive health and emergency treatment; all day, every day.

Health service thus became one of the most devolved sectors in the new constitution. Many felt that much as there were some shortcomings and even several things wrong in the constitution as it was, but devolution of health services was not one of them. It was the considered opinion of various stakeholders that devolution of health was essesntially a great idea but that the hurried manner in which the functions were devolved was the cause of much of the acrimony.

The general Kenyan public is increasingly getting open minded, amidst a fast changing patient care environment. They may be already questioning if /whether health care workers participate in making decisions that deny them quality health care or even shorten the lives of patients. Health care professionals must therefore anticipate this demand for quality care from the citizens and prepare themselves to provide information to the public. A number of incidents are cited in this chapter on what the citizenry are expressing, how they feel about the quality of health care in Kenyan public hospitals.

3.0 The Citizens Aspirations on Their Right to Access Quality Health Care

Heath was a priority aspiration for all societies. For example, Australians in their run up to their nation's 2012 elections clearly placed health care ahead of other key policy areas, including keeping the national economy strong, employment and infrastructure.

Five-decade long expectation to fight the tri-enemy of disease, ignorance and poverty for us is long enough. Kenyans had a basketful of expectations at independence. Most of those hopes certainties and optimism were captured by school children in musical compositions. Everything looked like a possibility (Kenya@50, *The Standard*, Pp. 13). Then came 'Health for all by the year 2000; The Alma-Ata 1978 declaration; Elimination of mother to child transmission of HIV by 2015; The MDGs were by 2015, we are past there. In 1981, WHO had envisioned that … given a high degree of determination, health for all could be attained by the year 2000. We still have health for all by 2020 and sustainable Development Goals (SDGs). As unrealistic as it might appear we need not wait that long, shifting the goalposts has not helped.

Scientific breakthroughs had given hope to an otherwise previously gloomy situation. For example, Dr. Jared Baeten of the University of Washington announced *Risk of catching HIV from an infected partner was almost eliminated with this once-daily pill.*

These results of a study done in Kenya and Uganda were announced on 19th July, 2016[15] at the Durban International AIDS Conference in South Africa. The delegates discussed the UN target of ending AIDS as a global health crisis by 2030. The research reported that, 'HIV was virtually eliminated in this population,' whereby the HIV positive partner in the couple (two-thirds of whom were women) took antiretroviral therapy (ARVs), which suppress the HIV virus and stopped the progression the disease. Meanwhile, the HIV negative one took pre-exposure prophylaxis (PrEP), a daily pill which prevents HIV infection.

After years of debates, discussions and delays the promulgation of the Constitution of Kenya on 27th August, 2010 marked a major milestone towards improvement of health standards. This is now more urgent than ever before. These aspirations were enshrined in the constitution through prioritizing quality management as an integral component of the health care services.

The Constitution provided an overarching conducive legal framework for ensuring a more comprehensive and people driven health services delivery. It also seeks to ensure that a rights-based approach to health is adopted and applied in the delivery of health services.

Maybe Kenyans felt that competing national priorities took precedence over local upward-driven priorities. Previously the local leadership was not absolute in decision making; there were decisions that could not be made at the district level and were left to the higher national level.

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[15] OdaOttesenForMailonline, 19 July 2016 *Risk of catching HIV from an infected partner is almost eliminated with this once-daily pill.*

Even the care providers were conscious of this Bukachi *et al.,* (2014) interviewed staff and this is an excerpt of a quote; 'We are given a plan by the ministry (of health) and we also look at our situation and decide on what we can do to make the situation better. What the national level brings may not be our priority because of the county's specific needs and problems' (health personnel). To the common mwanachi devolution meant bringing services near to them (in Swahili) 'kuleta huduma karibu' but more important was availability of these services 'huduma kupatikana karibu'.

Chapter 4 of the Constitution of Kenya, article 43, 1 states:

> (a) that *every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care*. Further, article 43, 2. States; *that a person shall not be denied emergency medical treatment.* The Health Bill 2015 (now Health Act) (got the president's assent in mid 2017) states *Every person shall have the right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act.*

Regarding emergency treatment The Health Bill 2015 (Health Act) states:

> *"emergency treatment" refers to necessary immediate health care that must be administered to prevent death or worsening of a medical situation.* Further *"medical emergency" means an acute situation of injury or illness that poses an immediate risk to life or health of a person or has potential for deterioration in the health of a person or if not managed timely would lead to adverse consequences in the well-being.*

The Health Bill 2015 (Health Act):

> *"health care services" means the prevention, promotion, management or alleviation of disease, illness, injury, and other physical and mental impairments in individuals, delivered by health care professionals through the health care system's routine health services, or its emergency health services. It includes pre-hospital care, stabilising the health status of the individual, or arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilise the victim*
>
> Whereas *"health facility" means the whole or part of a public or private institution, building or place, whether for profit or not, that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health service.*

Even as we insist on these rights as Kenyans, we should be cognizant of the fact that emergency care still remains underdeveloped, underequipped and basic, in both public and private health facilities.

The country did not have an organised national emergency care system, lacks specialised trained emergency care health personnel, and has not developed standard operational procedures and emergency operation plans. According to the The World

Bank, *implementation of effective, prioritised, timely emergency care has the potential to address 45 per cent of deaths and 36 per cent of disability in low- and middle-income countries*.

But let us take this a step further by asking some begging question: What can justify circumstances that would lead to refusing to provide emergency medical treatment to patients unable to pay, or transferring them before emergency conditions were stabilized? In practice, if an individual shows up for treatment at a hospital's emergency room, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition exists, if yes, then treat, stabilize and discharge/transfer.

What is a true emergency? Perhaps the answer lies in the beholder. No point going for a dictionary definition. But really a true emergency is when an illness or injury places a person's health or life in serious jeopardy and treatment can't be delayed. Crushing chest pain, asthma, stroke, broken bones, traumas, etc., are all true emergencies. Includes active labour (4cm and above cervical dilatation).

Definition from an authority: according to the African Federation for Emergency Medicine (AFEM) - *emergency treatment is the provision of initial resuscitation, stabilisation, and treatment to acutely ill and injured patients, and delivery of those patients to the best available definitive care, regardless of ability to pay*.
The golden hour in medicine is the period following acute traumatic injury or medical emergency such as a heart attack or stroke during which there is the highest likelihood that prompt emergency medical treatment will prevent death. Unfortunately many loose their lives or are maimed for life within this hour as they may not get the appropriate and timely critical services.

Thinking about charity care - How much of it can any for-profit hospital provide; that is uncompensated care that they can write off? What if from the beginning the hospital determined that the patient had an inability to pay? What of "bad debt" (where the hospital expected the patient to pay but then never received payment)? What measures are in place to prevent 'patient dumping'? All these scenarios presented can become very costly for the hospital. Something else to bear in mind all along are ethics and the law. It is about time Kenya came up with an act of parliament like US did - Emergency Medical Treatment & Labor Act (EMTALA). (See **18 hours' ambulance ordeal** and contrast it with **Mumbua** below).

According to the Kenya Council of Emergency Medical Technicians (KCEMT), by February 2018 there were only 68 ambulances in Nairobi. The entire nation of 41 million people had 354 ambulances. There was no single advanced life support ambulance in the country. The organisation with the highest number of ambulances in the country was the Kenya Red Cross with about 28 followed by St John's Ambulance that had eight. The market gap was palpable. In Nairobi an ambulance charged between -Ksh4, 500-15,000 depending on the distance. Interestingly NHIF & several medical insurance companies paid handsomely for ambulance services. Posted by Sirmie Karis Cantona.



Pic: People living in remote inaccessible places often require that health services be taken to them (Courtesy COBES Meteitei, Nandi escarpment)



Photo: An ambulance in a rush, at least one in every 10 Kenyans used to die in an emergency situation...

[Courtesy of Eunice Kilonzo, HealthyNation]

If we view health care as a right, who should be responsible for the provision of this right? 'You cannot predict when an emergency will walk through the casualty doors, but you are expected to be ready when that happens. That's the dilemma in our country' observed Prof. Wachira, an emergency care specialist interviewed in one of Kenya's dailies in November 2017.

Dr Wachira was taunted as the first and only emergency medicine specialist in the country. He alleged that emergency medicine parse was not taught in Kenya in Medical schools as it concentrated on inpatient. A few post basic courses have been mounted in Kijabe and Aga Khan hospitals for the last one year.

Who responds when this right is not met? I think as a community, we should do the "right thing" and provide it. Healthcare is expensive and just as our physiological needs (food, shelter, and clothing); it is our duty to get them starting from self-care, insurance etc.

According to the Atlanta Journal (2009) wrote "one cannot experience life, liberty, and the pursuit of happiness when one is sick and not cared for" (ajc.com Blog by Robin Miller on Oct. 21, 2009). Yes, Kenyans cannot have life, liberty or happiness without health care.

When we are sick we cannot fulfil the Kenya dream of becoming an industrialized nation by 2020 and vision 2030. The American dream (coined in 1931 by historian James Truslow Adams) for that matter was that: Anyone, regardless of their background and standing, can aim for a more prosperous life for themselves and their children.

Was quality affordable health care something Kenyans themselves or their children hoped to achieve (- if they worked hard, if they were lucky, if an opportunity presented itself or how)? How do we remove this uncertainty?

How best can we articulate or espouse this dream? What was the missing link for the electorate, for the leaders, for health care providers? Or rather how do we stabilize the health system, create continuity and certainty? There was need to remove the wedge between the public and the health professions and work for a common good. We need people who can champion the Kenyan dream.

18 Hours' ambulance ordeal

On 5th October 2015, A. M., a 33 year old male, was involved in a hit and run road traffic accident along Waiyaki Way Nairobi. Throwing him head-first onto the tarmac at Thiong'o area. Unconscious and the clock ticking fast against him, A.M would spend the next 18 hours in an ambulance as paramedics rushed him from hospital to hospital in what was dubbed by main media and social trends as '18 hours' ambulance ordeal'.

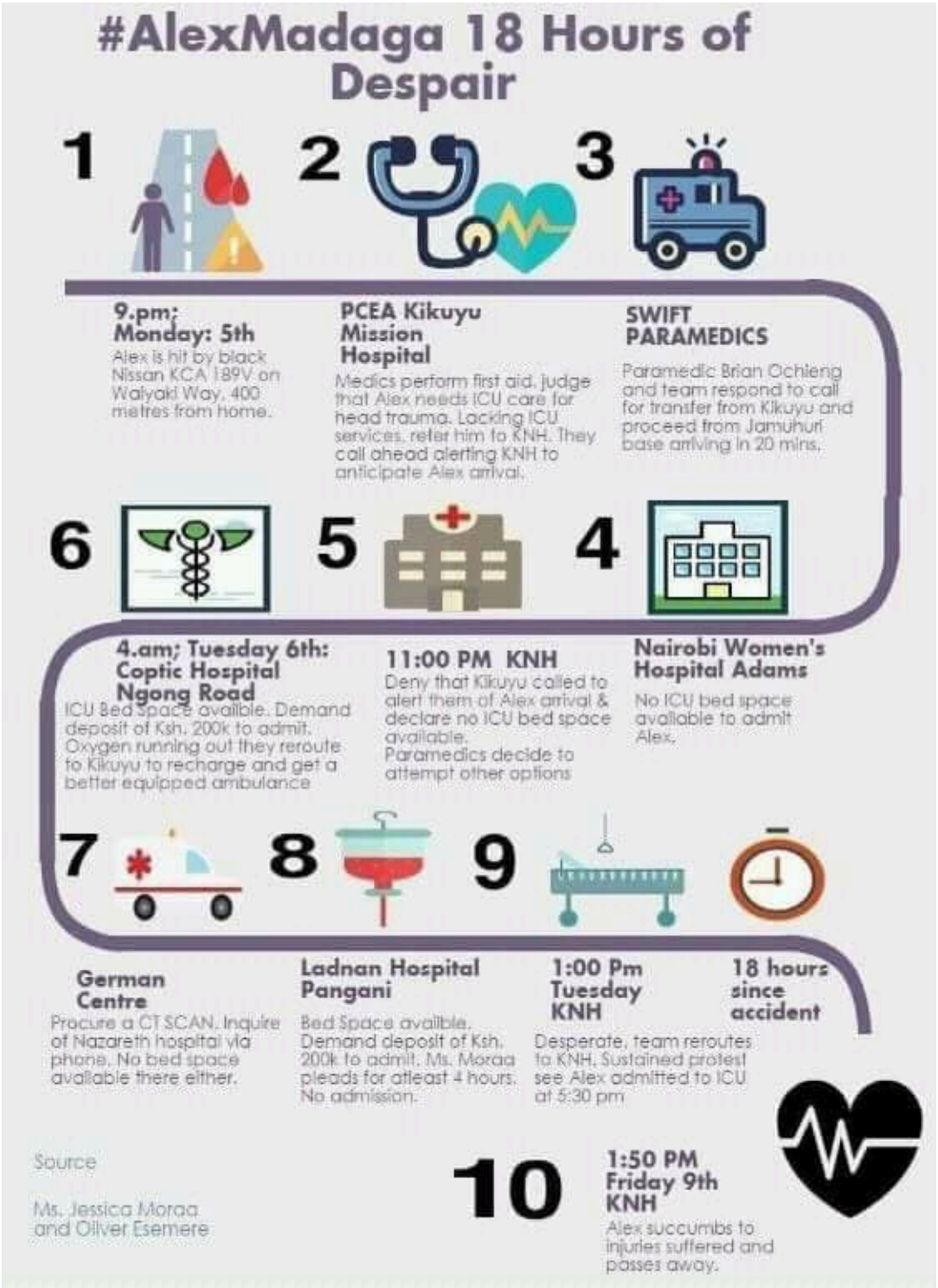
His name conveniently became the 'ambulance' patient. If the lineup is anything to go by, he is alleged to have been taken to five hospitals: A, B, C, D and E. The first hospital referred him for specialized treatment. In one hospital they could not raise the Ksh 200,000. The main problem was largely lack of critical care facilities – No ICU bed was available.

He died in E after some 33 hours since admission after being admitted. The same hospital E they had checked-in earlier and left. The Cabinet Secretary Ministry of Health ordered an inquiry into the matter by The Kenya Medical Practitioners and Dentists Board [KMPDB].

In the preliminary findings: in some of the hospitals 'something' was done for the patient, in others 'nothing' was done, in others its alleged that he was required to produce an admission deposit in a 'no-money no-admission' kind of policy, one hospital was reprimanded for referring without a qualified clinician to accompany (a student paramedic spent the 18 hours with him in the ambulance).

In yet another hospital 'he was referred back to the referring hospital'. Finally two of these were supposed to answer for alleged negligence which could have led to the death of A. M. The case attracted a lot of public and media attention and was still being pursued by the concerned parties.

May be summarized by what Gen J. posted on *Enlightening Nurses* on social media on



Used with permission from I. Shivekah on *Enlightening Nurses*: Acknowledge source Ms. J.Moraa and O. Esemere (Locations and identities used with a disclaimer)

18th September 2017. 'We cannot have critically ill patients who have been brought in on life support queuing to be admitted for intensive care stabilization. The patient barely made it to the casualty department of the referral hospital '…you get turned back because you are not the only one needing critical care and moreover you have to join the queue?' Wait like others?

A fictional movie '18 Hours' produced by Bill Atwani premiered in Nairobi in November 2017 courtesy of Emergency Medicine Kenya Foundation. This is a fictional film that follows a rookie paramedic who spends 18 hours in an ambulance for a life of an RTA victim who struggles to get admission into a hospital

Post Script

Exactly two years later, on October 5, 2017, a chief magistrate's court in Nairobi awarded A.M's family Ksh2.5 million as compensation for his death. He also awarded them Ksh189,659 for special damages; Ksh150,000 for the pain and suffering, and a minimum wage compensation of 20 years amounting to Ksh2,068,248 (the late A.M's monthly salary used to be Ksh50,000 per month). [Please you might wish to colloborate above information with the inset diagram *#AlexMadaga 18 Hours of Despair*]

A referral strategy(2014-2018) for the country has existed since 2014. Now we have laws, thenthe goodwill. Although emergency care was not explicitly included in the NHIF out-patient package, in June 2017, it entered into a partnership with *Emergency Plus Medical Services* (E-Plus) to roll out emergency road rescue and evacuation services. This is meant to benefit all NHIF members and their declared dependents. NHIF members were required to call 1199, which is a toll-free number, or 0700395395. An event *The 4th State of Kenya Healthcare 2017* sponsored by The British Council in Kenya convened on 24th November 2017 to discuss this among others. (See section **4.9.2** of this book on Universal Health Cover).

It is still debatable in general whether healthcare is a right and not a privilege or it is both a right and a privilege. In no uncertain terms it is a right under the Constitution of Kenya. In the Bill of Rights, many rights are either granted or protected, and healthcare is one of those granted.

Well said, but how much of a right is it if one must pay in terms of effort, time and frustration to achieve this right? In this case I am referring to people struggling to receive basic care, or the minimum that ought to maintain their human dignity. (See **18 hours ambulance ordeal** above and **Shot and left for dead** in Chapter 2).

The first story showed us inadequate critical care facilities and uncoordinated referral system. A zigzag is the best that could describe the tracks covered by these unfortunate trauma victims, for those who lived to tell - an ordeal it was.

Much as the national referral strategy exist on paper, in a real situation like the ones above it fails the test miserably or may be no one remembers it (or does it appeal to some hospitals and not others?). It is notable that all the hospitals in the two stories were within the perimeter of Nairobi city or thereabout.

Under PART II - RIGHTS AND DUTIES, The Health Bill 2015 (Health Act) provides in Section **7** on Emergency treatment that:

(1) Every person has the right to emergency medical treatment. (2) No person shall be denied emergency treatment by the health service provider of first contact provided the provisions of section 54(1) (e) have been implemented.

(3) For the purposes of this section, emergency medical treatment shall include-

(a) Pre-hospital care; (b) Stabilizing the health status of the individual; or (c) arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilize the health status of the victim.

(4) Any health care provider who fails to provide emergency medical treatment while having ability to do so commits an offence and is liable upon conviction to a fine not exceeding one million shillings or imprisonment for a period not exceeding twelve months or both.

(5) Any medical institution that fails to provide emergency medical treatment while having ability to do so commits an offence and is liable upon conviction to a fine not exceeding three million shillings.

On the other extreme ethical dilemmas as well as other forces that have an interest have a bearing on access to care. The Kenya law is silent on what the care providers ought to do. Many treatment roads are hard to retreat from once you start down them.

When we are just spending a great deal of money and resources for an almost assured poor outcome should the option of 'switching off care' be offered? (See **Mumbua** below). Others may have had a good chance of recovery if admitted to the Critical Care Unit, but then no bed is available for this new patient as seen in the **18 hours ambulance ordeal** above.

This was the era of Bill of Rights and actions by health care workers that left room for litigation needed to be avoided. Since cases like *Mathew Okwanda Versus Minister of Health and Medical Services & 3 Others [2013] Eklr*, High Court at Nairobi[16] one citing this constitutional provision have not been unusual. Chapter 4 of the Constitution of Kenya, article 43, 1 states: (a) *that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care*.

Further, article 43, 2. States; *that a person shall not be denied emergency medical treatment*. Does the Constitution indeed stipulate a general right to health care, or a patchwork of rights to certain aspects of health care? (Health Affairs blog, 2015). What issues we rare likely going to emerge over time from both constitutional and statutory law? See Mathew Okwanda Versus Minister of Health and Medical Services & 3 Others [2013] Eklr after **Mumbua** below:

Mumbua

Mumbua (not her real name), a 56 year female patient was admitted in Critical Care Unit (CCU) of a Kenyan public hospital. She was ventilator dependent by tracheostomy (an artificial hole made on the throat to facilitate breathing, bypassing the normal passage from the nose to the lungs). She is a retired primary School teacher, a protestant Christian, married and a mother of 7 children.

She was admitted with ascending paralysis which started on the lower limbs progressively to affect Respiratory muscles. Mumbua could not feed, move or breathe without help (mechanical ventilator). Doctors made a working diagnosis of Gullaine Barré Syndrome (GBS) or its variants [never became conclusive].GBS is a debilitating illness, more sudden in onset but also life threatening because the

paralysis may affect muscles of breathing).

Wikipedia defines Guillain–Barré syndrome, as an acute polyneuropathy, a disorder affecting the peripheral nervous system, ascending paralysis, weakness beginning in the feet and hands and migrating towards the trunk, is the most typical symptom, and some subtypes cause change in sensation or pain as well as dysfunction of the autonomic nervous system. It can cause life-threatening complications, in particular if the respiratory muscles are affected or if there is autonomic nervous system involvement. The disease is usually triggered by an infection.

She went in and out of depression many times. She was managed by the psychiatrist with counseling and antidepressants without much improvement. At one point after one year she summoned her children to the bedside. She was only able to move her eyes. It was not possible to ascertain what exactly she communicated to them. Around the same time, a full hour memorial service was held inside the Critical Care Unit staff lounge as a joint effort between CCU staff, the chaplain and the relatives. [This type of service was the first of its kind, just falling short of what would usually be done in a funeral context].

The opinion of experts from three medical disciplines; neurosurgery, anesthesia and internal medicine (physicians) was that the condition was irreversible; it was only expected to deteriorate until death. That is, she wound never be able to live without total life support with ventilation, nasogastric tube feeding, turning and cleaning.

Mumbua was very close to the CCU staff, they knew her likes and tastes; for instance she was fond of pediatric patients who got admitted the CCU bed next to hers. She had been moved through all the six CCU beds slots at different times of her stay. Her cognitive functions remained intact most of the time. She made friends even in that state e.g. whenever a nurse would go for annual leave, one wish they had to come back and find Mumbua still alive'.

She was resilient and could pull through odd and ends circumstances including multiple drug resistant organisms in her spectrum etc. A silent attempt for 'less aggressive care' was contemplated in a ward conference to discuss way forward. The family was divided on this; however they consulted their lawyer who constrained them against seeking to terminate life.

At times stress levels would get high among the nursing staff on advocacy and health care provider's Christian perspectives on end-of-life issues. Nursing care was performed professionally -the patient was suctioned, put back on ventilator, bathed, fed, turned, and her dressings were done.

An order in writing was issued by hospital management to resume full support. Efforts were made for fundraising for a portable mechanical ventilator for home use. Mumbua went into deep coma 3 months to her death after 1year 4 months in CCU. It was thought she succumbed, possibly due to complications of prolonged hospital stay like hospital acquired infections. She had accrued a medical bill of Kshs 5 Million (USD50, 500) in the year 2011. A support group (Gullaine Barrè Support Group) was founded in her honour.

(Consent and permission to use and publish this case given by her significant other) appeared in Kamau,S.,Kirima, J., Mwangi, H. (2014). Ethical Issues for doctors and nurses, a case of Moi Teaching & Referral Hospital, *Kenya Journal of Health Sciences*. Vol 2. (Used with permission).

Since then, cases like Mathew Okwanda Versus Minister of Health and Medical Services & 3 Others [2013] Eklr, High Court at Nairobi citing this constitutional provision have not been unusual. The courts on their part hand down interpretation of the text of the constitution the best way they know how. (See **Okwanda versus Minister of Health** below):

> **Okwanda *versus* Minister of Health**
> The petitioner described himself as a 68 year old patriotic Kenyan. He started his career as a store keeper in 1962. In 1996, he was diagnosed with diabetes mellitus, an illness that required proper care, diet and medication. His complaint was that the cost associated with managing the illness was prohibitive given the fact that he had retired from active service and he has no means to take care of himself. As a result his health was at the risk of imminent and further deterioration. Article 43 of the Constitution 43. (1) Every person has the right (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care 43. 2) A person shall not be denied emergency medical treatment. Under Article 21, the State is obliged to take measures including the setting of standards to achieve progressive realization of the rights guaranteed under Article 43(above). The right guaranteed under Article 43(1) (a) is premised on establishment of a "standard." This standard must be judged in a holistic manner. The petitioner also claimed that he was entitled to receive reasonable care and assistance as an older member of society pursuant to Article 57.
>
> Mr Okwanda also sought free medicines and drugs to take care of his condition in addition to free treatment at the States prime hospitals. It is not unreasonable for the petitioner and other concerned Kenyans to demand that a concrete policy framework be rolled out and implemented to address the containment and treatment of various health afflictions. These, however, are matters of policy which the State is expected to address in light of its clear constitutional obligations. On the whole therefore, while the judge found that the petitioner's grievances were serious, quote: "it is with great sympathy that I find that I am unable to grant the reliefs sought in the petition. Consequently, the petition is dismissed with no order as to costs". [Source: Judge D.S. Majanja dated 17th day of May 2013, delivered at Nairobi, Kenya]

Section 5.2.1(v) of the Kenya Health Policy Framework 2012-2030 addresses this provision of quality emergency health services at the point of need regardless of ability to pay. Emergency conditions are those health conditions that are of sudden onset in nature; are beyond the capacity of the individual/community to manage; and are life threatening, or will lead to irreversible damage to the health of the individual/community if not addressed.

The emergency treatment will be provided by the nearest health facility regardless of ownership (both public and private). Implicit in this right is the need to provide quality health services that are accessible to the population.

Questions were increasingly been asked about the role of health care professionals regarding access to quality health care for patients. The general public has become better informed and are more inclined to demand for quality care, amidst a fast changing patient care environment.

[16] (Nairobi Law Courts), Petition 94 of 2012. 2 http://kenyalaw.org/caselaw/cases/view/88803

This observation was made by Maina & Kibua (2008) when they did an assessment of service delivery capacity in district health care systems in Kenya. The public may be already questioning if /whether health care workers participate in making decisions that deny them quality health care or even shorten the lives of their patients.

The IOM report 1999 reported that 48,000-98,000 deaths yearly in the US could link to medical misadventures (or errors). Health care professionals must therefore anticipate this demand for quality care from the citizens and prepare themselves to provide information to the public (Please see Appendix IX).

Qualitative information such as patient-provider relationships, effectiveness of the procedure, patient satisfaction, and healthy behaviours accrued are not reimbursed or costed (Porter-O'Grady & Malloch, 2015). Yet these are the aspects of care that contribute towards making a difference in terms of patient experiences. It takes a great deal of time and effort to achieve them. We need to look at things differently, it cannot just be routine, if we expect the quality of our care provision to improve then something needs to be done differently. First and foremost by engaging our mind into our work (see **The unique, the odd, the unusual, and the out of place** below).

The unique, the odd, the unusual, the out of place

Look out for the unique, unusual, odd, out of place etc. My undergraduate teacher used to say: 'A patient is NEVER the same. If you don't find something different, you aren't assessing enough OR our interventions aren't working. EITHER WAY, something different needs to be done oe done differently'. She discouraged the students from working in a 'don't tell', 'don't ask' environment. -With this little nagging, we started down the path of learning (classroom, simulation, and orientation at the bedside). It's amazing what just giving us a challenge to do actually did. We would ask much deeper questions and we weren't just ready to settle for the status quo. She believed that nursing schools should use simulation labs (though ours had only a few manikins) and take advantage of online classes to educate more students.

Kenya's Vision 2030, details the long-term national development agenda- aiming to transform Kenya into a globally competitive and prosperous industrialized middle income country by 2030. Health is one of the components of delivering the Vision's Social Pillar, with an ambition to make Kenya a prosperous nation with high quality of life by 2030 whose overall goal in health is to have an "equitable and affordable healthcare at the highest achievable standard" to her citizens. One could not, really, separate the economic issues from social and cultural ones especially in a society like ours.

The Vision 2030 makes particular reference to good education and to healthcare for all. The quality of education and health services will in fact determine whether the promise of Vision 2030 broad national development plan to achieve "a globally competitive and prosperous country with high quality of life" will be shared by everybody, especially among the population living in absolute poverty levels (which still remains high at 46%). Kenya had become relatively unequal in terms of poverty index (the gap between the haves and have-nots had continued to widen); alleviating extreme poverty by 2015 thus was not achievable.

The Poverty Reduction Strategy Paper for the Period 2001-2004 (Republic of Kenya, 2000) had defined poverty as *the inability to feed self and family, lack of proper housing, poor health and inability to educate children and pay medical bills*. Less than US$ 1.90 a day in purchasing price parity terms 2011. According to this definition, 15 million Kenyans were poor in 1997 and currently an estimated 56% of the Kenyan population then lived below the poverty line.The government adopted poverty lines of Ksh



Most Kenyans live in the rural areas, erking a living from subsistence farming (Photo Sinoko area Kakamega courtesy of Charles N. Musee on Health Access Worldwide HAWI)



SDG goal No. 3 Good health & wellbeing. It's the people that matter, where they live and how they live then becomes our concern in the achievement of Sustainable Development (SDG) goals. (Courtesy of *Africa Agenda 2063*)

2,648 (US$ 26.7) in urban areas and Ksh 1,238 (US$ 12.5) (1USD=102 Kshs mid 2016) in rural areas per adult per month. The figures, however, were indicative of income but did not take into account expenditure. Maybe we could borrow from the example below:

The average Kenyan's daily_life was ably described by Leah Oyake-Ombis (Business Monthly-Sector review, Sept. 2017 p49). *56% of Kenyans live below the povery line... support the "kidogo" economy -synonymous with majority based on small amounts people buy. e.g. 1 cup of cooking oil, a handful of washing powder, or a squeeze of tooth paste etc.* Kidogo is Swahili for small.

In March 2017, Twaweza East Africa released results from a mobile phone based household economics survey in Kenya dubbed 'going without?' that indicated that at least each person in the house needed Kshs 99 to meet their needs. 4 in 10 of those surveyed admitted that they went for a whole day without a meal in the preceding 3 month period (August - October 2016) of the survey.

Maternal education has been noted over the years to have a strong correlation with child's health and survival. The development blueprint stipulates that to improve the overall livelihoods of Kenyans, the country has to aim at providing an efficient and high quality health care system with the best standards (Vision 2030 brochure July, 2007). To realize this ambitious goal, the health sector defined priority reforms as well as flagship projects and programs including: restructuring of the sector's leadership and governance mechanisms; improving procurement and availability of essential medicines and medical supplies; modernizing health information systems; accelerating health facility infrastructure development to improve access; human resource for health development and developing equitable financing mechanisms as well as establishment of social health insurance.



Pic: Community level outreach and door to door (Picture used with permission)

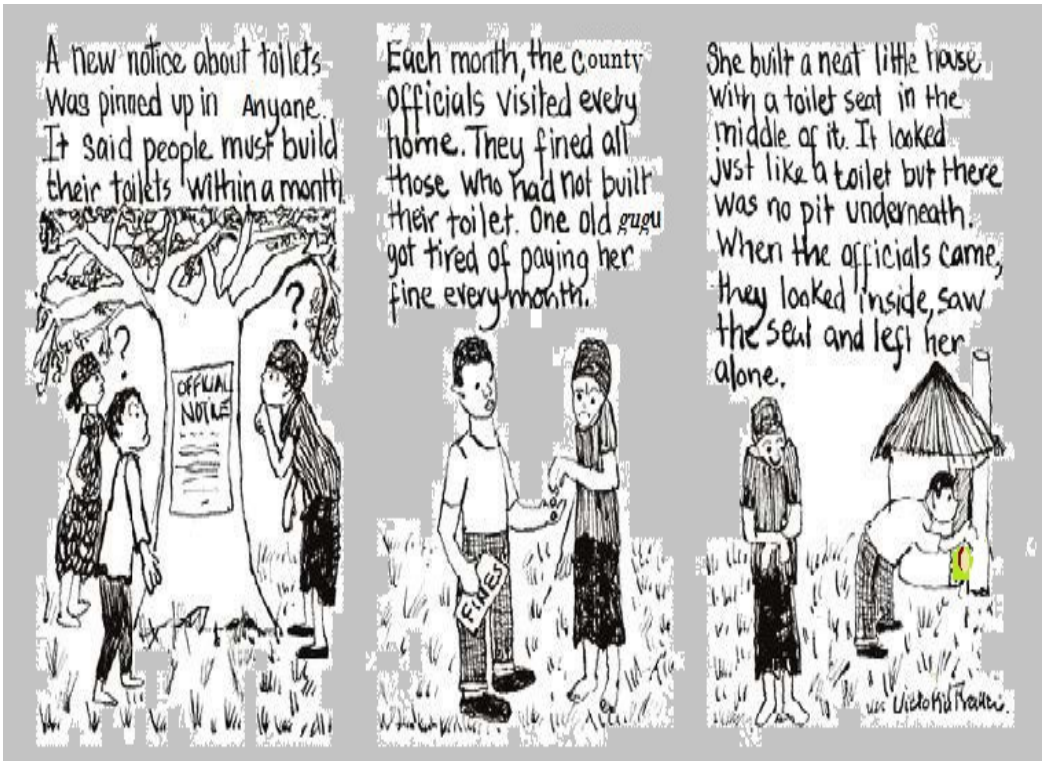


Fig: Enforcing the basic health benefits *vis-a-vis* individual or otherwise cultural inhibitions
(Adapted from Community Eye Health Update)

3.0 Evaluating Quality Health Care: But According to Who and Whom?

3.1.1 A most basic service

Endeavoring to interrogate quality of health care must start with evaluating the most basic health service: hygiene and sanitation. This author believes that a public health specialist would do a better job than what has been attempted here. Therefore the scope will mainly be what was already in the public domain in the recent times.

In the last week of September 2017, Marsabit County (areas of North Horr, Dakana) lost 25 people to cerebral malaria, more than 100 admitted and 186 others on treated. In Tiaty area, Baringo County 15 people had reportedly died from cerebral malaria. Cholera outbreaks in several parts of Kenya in the recent years pointed to some dysfunction in the health system.

The less than desirable performance of Kenya's health system could be attributed primarily to lack of concerted effort in managing crisis. From early to mid-2015 to mid- 2017 the health system failed to deliver a most basic health service like containing cholera outbreak. It spread to more than 10 counties, over 3500 cases, about 70 people died.

Let us consider the four scenarios conveniently labelled- *wedding buffet*, *seminar treat, who was who* and *full force*:

Wedding Buffet

In mid-May 2017, about 400 guests had attended a garden wedding party at Karen, Nairobi. They were drawn mainly from counties in western Kenya but also from Nairobi and its environs. A few came from Eldoret and Mombasa. They also included two Germans who happened to be first-time visitors to the country. An outside catering firm had been contracted to handle the meals. They served delicacies: fish, meatballs, spinach and rice etc. In less than a week after this, there was a cholera outbreak which claimed 3persons with several hospitalized. Efforts to track down all those who had attended the event were made.

Quotes from some of the affected: 'I remember one of the cateresses was diarhea-ing a lot but was allowed to continue preparing food'. '*Hiyo dish iliniactia serious'*. Sheng dialect perhaps to refer to the symptoms - she was down with severe effortless diarrhoea, abdominal pains, and dehydration. Isolated cases had since then been confirming cholera all the way to June 2017.

Seminar treat

In late June, 33 out of the 400 medics (mainly doctors) attending the 4th International Scientific Lung Health Conference in a Nairobi hotel were admitted to hospital after contracting what was believed to be cholera. The Ministry of Health which had sponsored the event was at pains to deny the outbreak. Again an outsourced catering outfit that had brought in packed lunch was blamed for the contamination.

Rapid tests tested positive, the victims themselves shared their results on social media as they were convinced it was cholera. One doctor was put on dialysis secondary to renal failure from severe dehydration. A week or so later cases of cholera were reported in several estates in Nairobi including Huruma.

The response to contain the outbreak was less than desirable. The Ministry of Health for some time toned down the matter as food poisoning. It took time to reach the decision to quarantine the whole hotel, get to the bottom of possible contacts and source(s) etc. The then Nairobi governor ordered a probe almost 10 days after the incident. The decree also included activating 4 out 6 cholera treatment units in the city.

Apparently, public relations (PR) and politics worked in cohort to overrun public health. The situation was complicated by possible link to a senior politician to the hotel and, 2017 being an election year certain quarters tried to gain some mileage out of the incident.

Who was who?

This episode happened around July 14th about a month after the *seminar treat* above. The list read like *who was who* involving at least 2 cabinetsecretaries, 1 principal secretary and dozens senior government officials alongside other patients (including some reputable hotel staffs). All of them happened to have attended Kenya Trade Week/Trade Fair at Kenyatta International Convention Centre (KICC) in Nairobi's central business district. They were admitted with what was suspected to have been cholera .

Official figures released on 14th July 2017 by Nairobi County health department indicated 33 cases of cholera had been in the month of July bringing to 96 cases and 4 fatalities in two months. Unofficial figures were diverse and also much higher.

On 17th July the government cancelled all food handlers', water vendors' medical certificates and ordered fresh medical examinations. Hawking of food and outsourcing of

food by event organizers and hotels was also banned. Distribution of chlorine to treat drinking water and hand washing to the affected areas was done.



Pic: This burst open sewer had been running for sometime. See in the background residents drying posho and other grains in the proximity of the effluence oblivious of the danger (Photo courtesy of Kericho Renaissance Network)



Pic: Water filters distributed through the *Nyumba Kumi initiative* had the assurance of safe drinking water. An added benefit was promotion of hand washing hygiene in the households [The model in the picture (right) was distributed by St Mary's Pastoral Center, Catholic Diocese of Nakuru. Other models included *Uzima Filters* (left). Note the use of locally available materials like buckets]

By July 19th 2017, 67 patients were admitted at Kenyatta National Hospital (KNH), 4 Mukuru Kwa Reuben Health Centre and 12 in other health facilities within Nairobi County. Many of the casualties came from the slums of Mukuru Kwa Njenga, Mukuru Kwa Ruben, Kibera and Imara Daima Estate among others.

Kisumu was the next city to be hit, the victims included 34 prisoners from Kodioga GK Prison. They were discharged from hospital on 27th July 2017 after treatment. There were some cases reported from Garissa with 10 other counties on high alert. These included Tana River, Vihiga and Murang'a. Some of these had traditionally been cholera hotspots. By 3rd August 2017, Nakuru had reported 7 cases in 2 weeks. On 24th August, Kilifi reported 5 people had tested positive.

Full Force

On September 3rd 2017, about 92 police officers who were being accommodated at Multi-Media University (MMU) in Kajiado County were suspected to have gotten cholera. 54 of them were admitted. The food was said to have been sourced from the Nairobi Area Police Canteen.

An officer who sought anonymity [17] "… this thing started from the canteen. I wish you visit the place; the sewer is burst and effluent deposit near the kitchen". Around this time 22 members of the National Youth Service, Bura camp in Tana River County were being treated for cholera.

Lesson learnt: While public relations, politics, and health knocked heads and suffocated each other the deadly bacteria spread. Outbreak spared no one from high profile to common man from the slums. This meant several things but most critical it pointed to a break in the health systems. We needed to work towards a system that works, responds and achieves credible results with some degree of independence.

With the onset of heavy rains and flooding reported in several parts of the country, the drainage structures in place were strained to the limits. It had of late been reported in the media that in some of the informal settlements in Nairobi, 'raw' sewage flowed freely and clean drinking water was a scarce commodity.

The media[18] was awash with news coverage in early September of part of Eastleigh's California Estate in Nairobi County which was unreachable for a month due to raw sewage effluent that had taken over a whole street all the way upto Eastleigh Section III.

'You do not want to tell me there was garbage at KICC where the cholera cases came from, cholera was a matter of personal hygiene…', countered the then Nairobi Governor attempting to absolve his administration from blame. Meanwhile Wakulima and Marikiti markets among other sites during around that period had to put up with heaps upon heaps of rotting uncollected garbage.

It was difficult to deny that in resource-constrained settings a good number staff working in five star hotels, companies, serviced apartments and even high end medical facilities were underpaid, lived in informal settlements, walked to and from work. It was no secret too that a big proportion of city residents ate their meals from eatery joints operating in the open air.

There were questions around professionalism in primary health disease surveillance, reporting and public health campaign. Victims were reportedly being transported/referred across distances instead of containing the spread at source.

Social class played out *vis-a-vis* the ability to afford medical care at different hospitals. This meant that victims were separated with more health facilities having to 'unnecessarily' deal with a small section of the epidemic. The social economic bias approach in handling cholera outbreaks is beyond the scope of this article but there was

room to interrogate it further.

It was unfortunate that two out of the three scenarios were happening during the national nurses' strike. '…without nurses you will not win the war on cholera…' –Kenya National Union of Nurses (KNUN) acting Secretary General while addressing members on 44th day of the strike at Uhuru Park, Nairobi.

Cholera is a fast developing highly contagious water-borne disease caused by the bacteria *Vibrio cholera.* It causes severe dehydration as a result of severe diarrhoea and vomiting, it easily complicates to multiple organ failures easily. An alert needs to be issued, cholera centres activated. Since the faecal-oral contamination was to blame, this brings into question food handling, personal hygiene, hand washing and water treatment among others.

As much as the scenes above played out broadly in public domain, this author does suggest they were all confirmed cholera cases. However the now 'regular' cholera outbreaks in Kenya pointed to a dysfunctional health system. We needed a coordinated plan to prevent and manage cholera in the country [Excerpt from this author's blog].

Deliberations during the *2nd National Sanitation and Hygiene Conference* held from 7th to 9th February 2017 at Safari Park Hotel, Nairobi observed that the constitution of Kenya Article 43 recognises sanitation and hygiene as a *"... right to a clean and healthy environment"* to all Kenyans. This basic necessity contributed towards better health, dignity and quality of life.

Universal access to safe drinking water, sanitation and hygiene had been a long standing national as well as international goal. According to Dr Cleopa Mailu the Cabinet Secretary of Health, it had been documented that for every Ksh 100 (1$) spent on sanitation and hygiene, there is a Ksh 550 (5.5US$) return. Kenya had made a commitment to reduce by 63 percent the proportion of population without access to improved sanitation under the MDG's, but it was not possible to achieve this by 2015.

According to UNICEF country representative Werner Schltink, every year more than 5000 children under the age of 5 died of diarrhoeal diseases in Kenya. In general mortalities arising from unsafe water and sanitation contributed to 5.3 percent of deaths in Kenya annually. This was unacceptable since sanitation related diseases were preventable. Only about a third of Kenya's population had access to a hygienic and private toilet. An estimated 5.6 million Kenyans had no toilet whatsoever; they had to relieve themselves in the open. WHO sponsored a mass media program 'Charging Currents' that distributes water dispensers (drinking and handwashing) and water treatment for families in the informal settlements.

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[17] Lilian Mutavi, *Daily Nation,* 5th September 2017. *More admitted in hospital amid cholera fears*

[18] NTV Tonight News 9th September 2017, 21Hrs

Through the community led total sanitation (CLTS) road map 2020 targeting behavioural change would see an end to open defeacation. Over the three years towards this conference the country had increased by 6 percent the number of open defeacation free (ODF) villages (from 1,231 in 2014 to 5,434 villages by December 2016) (See figure above: Enforcing the basic health benefits vis-a-vis cultural inhihitions).

Achieving these goals will require system wide concerted efforts by government, communities, households, private companies and development partners. In 2015/2016 financial year, 8 out of 47 counties made increased and dedicated budget allocations to implement community led total sanitation.

By mid-2017 Kipsingei village, Sotik Sub-County in Bomet County with 318 households, about a hundred of them were without toilets. Schools in the area were also badly serviced despite each having large population of learners.

It took the effort of NGO's like *Dig Deep* (UK) in conjunction with *Better World Canada* to put up toilet blocks in several primary schools, install water tanks to ensure hand washing. A good example was Tuiyotich Primary School with 551 pupils previously with only 2 pit latrines in dilapidated condition serving both genders.

Some of the other markers of adopting community led sanitation included hand washing, leaky tin, clothes hanging line, kitchen garden, compost pit, dish rack, long life insecticidal nets, improved ventilation of living quarters etc.

It was notable that water was also scarce in the Kipsingei location with most residents resorting to drinking unclean stagnant water from pools otherwise known as 'silanga'. During the rain, run off water carrying the 'night soil' to these water bodies would easily cause faecal-oral route infections.



Picture: (Right)The demonstration of leaky-tin for basic hand hygiene, (left) An improved pit latrine with leaky tin utilizing cheap available materials
(Courtesy of COBES - University of Kabianga)

3.1.2 Patient Satisfaction: according to who again?

It is with the above backdrop that this author asks - patient satisfaction was according to who? Satisfaction studies have been used to influence policy even though this has been criticized. For a long time client satisfaction was increasingly recognized as an important

outcome by earlier health services research (Aday et al., 1980). However, any institution that is mindful of customer feedback nowadays cannot ignore mass media and social media. Infact social media brought new dynamics.

The media is very much an essential component of good governance. Again this is the era of citizen journalism e.g. *U*report supported by The Standard Group. Much as a few times a section of them might have lacked in objectivity they had become an accessible forum to members of public to express their feelings in what could be referred to as 'keeping the finger on the pulse'(See The Suggestion Box in Chapter 3 below). Today people with access to the internet can comment about any topical issue and state it as it is, the way they feel it.

The *U*Report a citizen journalism website hosted by Standard Group was one such online site organizations would do themselves some good by checking regularly. The existence of FM radio stations in all regions of the country is an important infrastructure for facilitating dissemination of health care information and health education. Also more critical they are able to elicit responsiveness and feedback on topical issues trending.

The FM stations, which also broadcast in local languages, are more or less in touch with their constituents on a day to day life basis. They can be important tools that could be used to improve health of the community through dissemination of health care information.

The media is often recognized as the fourth estate (unofficially) of government. That is because it monitors the social political issues and keeps the government and society in check. The media can also be a very much a powerful tool for advocacy (e.g.by hosting debates as seen below) that health care providers can also use to push for policy changes (Staples, 2009).

The Scholarly Theory in communication asserts that the media do not tell us what to think but what to think about; this is what is referred to as the agenda setting. Depending on the power structure, can be used to manipulate public opinion to its own end.

Collaboration between British Broadcasting Corporation (BBC) and Kenya Broadcasting Corporation (KBC) - Channel 1 on 12th October 2014, 1800Hrs hosted a very captivating debate *#SemaKenya* [19] Panellists and members of public were discussing maternal health. The panellists were Hon. Dr. Robert Pukose, MP Endebess and Vice Chair to the Parliamentary Committee on Health, Dr. Sultan Matendechero of Kenya Medical Practitioners Pharmacists Dentists Union (KMPPDU) and Ms Eunice Ngari representing the Nairobi branch of Kenya National Union of Nurses (KNUN).

However, the media often finds health matters exposè quite 'newsworthy', the perception seems to be that the media's agenda is to make us "look bad," how exactly can we respond or manage this stressful experience to our advantage. We must keep in mind that 'bad news travel fast'. Treatment failures may – unfortunately – impact more upon community attitudes towards treatment than all the examples of success (see Making headlines below). A good example was the concern raised by the Catholic Church in Kenya that the tetanus toxoid vaccines administered during the kick-off WHO/UNICEF campaign (the first in October 2013, the second in March 2014 and the third in October 2014) targeting women of reproductive age (14-49 years) ostensibly to eradicate neonatal tetanus might have contained elements or traces of pregnancy hormone -

Human Chorionic Gonadotropin (HCG). They claimed, '*…Campaign is not about eradicating neonatal tetanus but a well- coordinated forceful population control mass sterilization exercise using a proven fertility regulating vaccine'*.

The matter might have been concluded and fears allayed but the damage had already been done. The Catholic Church does not support non-natural methods of family planning (*MaterCare International* medicalnews, February, 2015). The matter of HD-hSG vaccine preventing pregnancy in women was reported in *a feasibility study of a reversible safe contraceptive vaccine*.

Politicians took up the matter when the findings were released in September 2017, the height of a general election, each wanting to make some mileage out of it, referring to it as 'a covert women sterilization program under the guise of tetanus vaccination' (see **Making headlines** below).

Citizens' discourse apparently was clogged with catastrophic selective amnesia and was shaped by the political happenings and rarely pertinent issues like quality health care: http://softkenya.com/ngo/bunge-la-wananchi/. May be this is a case of '… how the public interest becomes neither public nor interesting', once alluded to by one Tony Proscio (*nd*) in one of his essays.

Proscio is a former Associate Editor with *The Miami Herald* in the 1990's described his work as… to pique people's interest…it has to grip people and stay in their mind. It is extremely important that all involved can see something positive coming out of the incident reporting for them to continue to participate in the process. The report needs to be shared and where possible made public, the latter is rarely the case in Kenya.

Making headlines

The challenge has been: 'our media is very episodic, follow up on similar deeper issues, incidents on such poor quality of health care are not followed up, tied together to draw conclusions. There is an inclination to go for the next thing denying Kenyans a much need finality of knowing what really happened. Recording and discussing critical incidents and near misses ought to be with a view to improve patient safety.

Learning from these incidents ought to be the ultimate aim of all stakeholders rather than pretending that we know 'what actually happened' or waiting to report yet another incident. This should happen from the points of view of media as well as the health care system and any other

parties involved. The hope we (might) have left is with the bloggers and social media, they being user generated (self-updating and uncontrolled) content were not officially recognized as credible sources of information' (points gleaned from a press panel).

[19] www.bbc.co.uk/swahili/kwa_kina/semakenya

Consider the following: a pull-out article entitled 'Bad medicine, the dark secrets, why most complaints on errant doctors never see light of day.'[20]

In another instance, two Kenyan television channels covered on the same day different story lines with a similar theme. One was dubbed *'The new cancer'* construed to mean medical negligence while another one run *'Utepetevu hospitalini…'* in Kiswahili implying laxity in a Kenyan hospital which could have led to loss of lives[21 , 22]. In another example christened - *'huduma duni za matibabu',* Swahili meaning low quality health care that had led to residents of that county demonstrating in the streets[23].

In another incident residents of Kuresoi in Nakuru County vented their pent up frustrations by forcefully entering and destroying Olenguruone Sub-County Hospital's property including 4 government vehicles, among them an ambulance. They were protesting what they perceived negligence that could have led to the loss of a boy's life. The incident was widely reported in the media[24.]

An open letter by A.N on behalf of the residents to the Governor, Nakuru County referring to the incident expressed the same and raised several begging questions some of which were, why there were no medicines in the hospital?; Was it true the ambulance did not have fuel for referral on that fateful day? It is notable that some parts of this sub-county then did not have a health facility 28km radius. A letter by a resident of Kuresoi was available on Facebook.

In the case below things were not as bad, but could have been better.

> …four days later he arrived at the orthopaedic clinic on a Friday. He had no appointment, and the surgeon to whom the note was addressed had held his clinic on the previous day *and would not be back until a week later*. The harassed sister, busy with another specialty clinic, found that he had no relatives in town, and no money, so she sent him to the orthopaedic ward in the hope that they might have a bed for him. At least one patient eased some space for him, so the two adults shared the 3x6 feet bed.
>
> The internist saw him. His wound had healed and he was fit for surgery, but the necessary screws, plates, adhesive drapes, and sutures were not in stock. And in any case there was a three months waiting list, so he had to wait 10 days, even for operation as a semi-emergency. A 'silent cheer' went up from the hospital's *staphylococci*, as they began to colonize his skin. Finally his radial nerve had to be freed from compression in its spiral groove, and his fractured humerus was successfully plated.

[20] The Standard ,May 13, 2013, pg. 6

[21] NTV, *PM Live 13.00HRS on 30th March 2011* and *NTV Tonight 21.00HRS on 4th April, 2011*

[22] Citizen, *Nipashe, 19.00 HRS on 30th March, 2011*

[23] Citizen, *Nipashe, 19.00 HRS on 30th March, 2011*

Two weeks later he returned to the level four hospital with suggestions for physiotherapy (a full day's engagement for each session) and instructions to return in a year for removal of the plate. He was in debt, and his family were hungry, but his' was a fairer case and it could have been much worse

(The story below was adapted from 'Referral is mostly a myth' *PrimarySurgery: Volume One: Non-trauma Chapter 1*.The background to surgery (See also **Referring for access** below).

Referring for access

Referral is an effective and efficient two-way process of linking a patient/client from one caring service to another.

Concerning referral, do not refer a patient to a facility that they cannot get access to the help they need. Give what you have and link/liaise for what you do not have so that the referral is not a waste of time and effort for the staff and the patient. Many times there is poor communication between the facilities. We assume what we do not know in matters of referral. The referring facility 'assumes' that the next level will assume responsibility for consultation, review or further management. [A veteran health care provider sharing her experience].

With the advent of ambulances belonging to the counties, there had been a tendency to 'clear and forward' overcrowding the higher facilities with what some felt were otherwise simple cases that could be cared for in lower hospital, turning some tertiary facilities into primary health care providers.

A recent study by Muchiri *et al.,* (2017) in Machakos County looked at ambulance services for community critical care transport needs. In one such a facility the large number of ambulances frequenting the emergency entrance blaring full siren and lights had become monotonous. Some referral hospitals reported a 100 to 340% increase in referrals in 2013/14. *Rarely does the referring facility try to find out what happened to each of the patients they sent,* quipped another care provider (See **The ill-fated escort** in Chapter 1 and **To have one of our own** above).

Prerequisites to a functional referral system include: accountability for provider's Performance and supportive supervision to improve performance, formalized communication and transport arrangements between the referring and receiving facilities, pro-poor cushioning against costs of emergency referrals, capacity to monitor the effectiveness of the referral system, a referral system health policy.

[24]QTV *Mwishoni Juma 20.00HRS, 10th Jan, 2015*

The elements of functional referral systems according to rss-baseline–assessment.pdf report (2013) include:

1. a strategy that is informed by the population needs and local context (for example, disease patterns in the population, cultural and ethnic diversity, economic capability, health-seeking behavior, and population expectations from the health system);
2. a strategy informed by health system capabilities;
3. referral centers that are adequately resourced according to agreed-upon service standards to meet referral demands;
4. systems that have active collaboration between referral levels and across sectors;
5. referring and receiving facilities with setting-specific protocols, which include guidelines on referral processes at both referring and receiving facilities; and
6. a unified referral records system.

To have one of our own

Option one: It was established from some source that a fully 'loaded' equipped *Toyota Landcruiser®* ambulance would currently cost the county government approximately Kshs 8M or more to buy (conservative figures only since 7 pieces of the Smith & Uzman ambulances handed over to the president by the British high commissioner to Kenya in March 2017 had cost Ksh54 Million). Conservative figures from Toyota Kenya might be above that. *Or else import a reconditioned used one at 1/4th the price, as long as it was not more than 8 years old by customs duty regulations*. In any case, add to this running cost in terms of: fuel, medical consumables, comprehensive insurance, personnel at least 3 ambulance crew members' emolument (including allowances), wear and tear and the not 'unusual' fraud, waste and abuse. These add-ons pushed that initial cost by a big fraction.

Often the cost effectiveness of such an investment got compromised by unpredictable response times during emergencies and usual breakdowns as affects many government vehicles due to poor or non-existent planned maintenance. This was compounded when the patient's relatives being required to pay an advanced bill calculated in Kshs per km of referral distance in most instances. The depreciation cycle of these vehicles got shortened by poor handling, vandalism and prolonged periods of being grounded at a time. The salvageable ones might be disposed for a paltry price as bonded vehicles. A typical scenario: An ambulance that the governor proclaimed was like an ICU and could sustain a patient for 5 hours. In less than 2 years, everything had to be sakanywad [- Sheng for painstakingly *looking for*] from the wards everytime it needed to escort and pray that the patient makes it to the destination.

On the other hand 'we must learn to enjoy some things without owning them', commented one county government official as seen below.

Option two: It would cost the county government Kshs 20,000 per day (600,000 per month) to outsource one new fully 'loaded' equipped *Toyota Landcruiser®* ambulance from reputable organizations with a good name in ambulance services. No concern for running costs by the county government like the case above because the contract would cater for everything including the personnel emolument for the 3 member crew, consumables.

A standard rapid response time of 20 minutes to a call for emergency evacuation or referral within or without of the county's designated radiuses. Services were free of charge to all the county's residents. It was unfortunate that in the last two months to governor's leaving office; the county could not pay for the 4 outsourced ambulances.

Consider the following case and how it would have been handled by either county. This was mid 2017, real case except for identifying features. Master NL needed an ambulance to refer him to KNH, 160 km away. The relatives were asked to clear Ksh101,000 owed to private health facility which they could not. This perhaps meant they were not likely to access the facility ambulance, so they looked for one, but it did not have oxygen and who knows what else. They set off on the journey minus the oxygen since no one was willing to lend them the precious consumable. NL died enroute.

The director of the facility gave this excuse when confronted with medical negligence allegations, 'we had expected them to get a St John's ambulance which has everything but they didn't…blah blah…' Other compounding features were: this was happening during the 3 rd week of the KNUN national nurses' strike that had affected all public hospitals; other emerging issues included escort, standards of operating an ambulance and a citizen's right to access emergency medical attention etc.

But then…

Kenyans were waking from some indeterminate state to become a litigious society and the medical field was not being spared. A Nairobi court on 25 th May 2015 awarded Ksh 4.3m damages compensation to a family after a contraceptive failed. In the case, a registered trustee hospital based in Nairobi was ordered to pay the couple what was calculated to be 'equivalent to enough money to raise the child from zero to 18 years'.

The couple already had 2 sons, the implant had been inserted into the upper arm, but after missed periods the woman was diagnosed to be 4months pregnant and alas she did not have an implant! The judge ruled that the unwanted pregnancy was a case of medical negligence. Even though they had to refer to other jurisdictions, there were challenges of balancing issues of public policy, ethics and religion etc. The hospital did not defend itself against the allegations, though it appealed the ruling in what had come to be a 4 year *and counting* battle. The matter was in public domain

[CivilCase3 of 2013 before High Court Judge Justice HPG Wameru]

It has been said that, 'A good reputation is hard won, easily lost, and sometimes never regained'. On 21st February, 2015[25] *'Bring back our babies …'* a storyline was being investigated involving a young couple who claimed to have lost their new-born twins at Pumwani Maternity Hospital, Nairobi County a few days before. The babies were said to have died after normal delivery, but the mother queried the circumstances surrounding the delivery, she had probably heard the babies cry, at least one of them did, she was somehow certain of that.

The babies had been separated from her and subsequent breaking of the news, bodies of the neonates brought to her in a carton. Initial DNA tests by the government chemists had shown that the dead babies were neither twin nor did they belong to this couple. So where did the twins go? Who did the two dead babies belong to? Could have been an accidental swap? Authorities queried whether a syndicate existed in the facility since a couple of such incidents had been reported in the past.

The working conditions in some of our health care organizations were generally not healthy, it could even be said to be toxic. Greater productivity was expected at the same time that the resources were decreased. Poor working conditions, lack of resources, heavy workloads, lack of participation in decision making, and limited opportunities for career mobility were some of the factors hindering nurses from giving quality care.

The delivery room

…the labour ward in one county hospital would only be described as 'less human' and this was a fair saying , it was inhuman to expect women to deliver and have their new-borns take their 1st breath here. Most likely the unit dated back from colonial times, it might have been designed for one or two women delivering simultaneously but handles three. Inside the room is one nurse midwife, one medical officer intern, a clinical officer intern, a bunch of nursing and clinical medicine students.

One infant resuscitaire, 3 high newborn holding bays, a fairly blood-stained suction machine, a fairly wet floor, the wall has been better days. It is cold and the lighting is less than adequate. The 3 birthing couches can only accommodate the woman's torso and she can hardly stretch herself. Two couches are opposite each other, no bedside screens whatsoever.

The couches had old marks of bloodstains. The number of deliveries per month through this facility was estimated to be around 350. The estimated size of the labour ward (with sluice-room and packs preparation room included) was 4 metres by 7 metres. This was hardly the size of a birthing suite for one mother in some private hospitals in Kenya.

In the words of the midwives, Pumwani had become a toxic organization to work in. It was apparent that they engaged in labour union activities as a means to mediate their pain, their psyche had been insulted so severely by a neurotic leadership style and negative publicity. 'Even after helping to deliver 80 babies in one night under resource constrained setting, one incident of some error is reported all over the media maliciously…'[26]

Nurses at Pumwani went on go slow from March to June 2015 complaining of shortage of staff among others. The ratio for Labour ward was 1 nurse to 10 mothers, with 80 to 100 babies delivered per day and 20-24 Caesarean sections per day. WHO recommends 1:1 (Perhaps we could say for Kenya 1:4 would be a bare minimum). See **The delivery room** as described of another public hospital above.

On 19th January 2015, the media run storyline of N M, an intern attached to Embu County Administrative offices who was charged in court for undermining the authority of a public officer on social media by questioning the tendering system and the running of Ishiara Hospital (a public hospital).

The arrest attracted criticisms from a section of Kenyans[27]. It was important to understand that public officers held office on public trust. In this regard it seemed that mass media and social media expose´ apparently were doing a better scrutiny in interrogating the quality of health care provision in Kenya (also see **Plague for Profit** below).

[25] K24 weekend, 21st February, 2015, 21Hrs

[26] Citizen Nipashe, 17Hrs, 11th April 2015

[27] http://www.nation.co.ke/counties/woman-in-custody-for-abusing-Wambora-on-Facebook/

Plague for Profit

An outraged citizenry, expressed its shock and disgust for blatant human rights abuse, assault to public health, greed and corruption by a media expose @ KTN Prime on 26th April, 2015 at 9pm: Plague for profit, finger-pointing between the Public Health Office and National Environmental Management Authority (NEMA) over lead poisoning at Owino Uhuru, a slum village near Kenya Metol Refinery in Changamwe, Mombasa.

The lead pollution from the plant has caused a lot of misery to the residents of Owino Uhuru slums. People had died, women miscarried and children had lost their cognitive abilities due to lead poisoning. For her efforts, P.O. an environmental activist paid a heavy personal price. She won the prestigious *Goldmanaward* for her efforts.

Hiding behind government bureaucracy, high profile politicians and corrupt incorrigible government officers, the factory operated in full accordance to the law. They had all the necessary licences and clearances despite the deadly pollution. Questions about how they managed to get all the licences and who facilitated them were brought up.

The public health office and NEMA especially, were hard pressed to explain how they cleared Kenya Metol Refinery and were unaware of the pollution going on. In a matter of such grave concern to the health of the residents it would have been better to be safe than sorry. It was possible that a social and environmental impact assessment prior, during and after the project had picked up all these but someone had turned a blind eye for their own reason.

If patient safety were a car, then trainees have long been the gauges, indicators and warning lights on the dashboard. Trainees are well placed to highlight the good and the bad of medical practice due to the ward-based nature of their work (Sarfo-Annin, 2015). Rotation-based work by trainees between departments and hospitals provides exposure to different ways of delivering care - provides them with a fertile ground to *being quite objective*. Trainees also carry out projects related to patient safety.

They witnessed many potential 'near misses'. There is no doubt that that their role as advocates for patient care is appropriate. However, the recent acknowledgement of trainees being 'eyes and ears' of patient safety has brought into focus that they are also the 'voice', and currently a quiet one.

'Ears and eyes'

In one incident four third year Bachelor of Science in Nursing (BSN) students from an unnamed institution shared how they witnessed the misuse of a subclavian haemodialysis catheter site by a qualified staff. They pointed out that the site was meant for dialysis only and not for other uses such as (specimen collection, drug administration and parenteral nutrition).

Moreover the staff did not as much care about heparinization and aseptic technique. The patient suffered a major episode after this, whether or not it was related was not clear. The students were banned from accessing the unit for the next 2 days.

The students did not report the incident immediately, it was only after they were confronted about absconding rotations that they disclosed what had happened. They appeared distressed. Which is which: whether or not to believe them; penalize them for absenteeism or for failing to report error incident or probe the error?

First impression

In yet another incident, students in a class of 42 pursuing one of the health care disciplines shared how they all without exception got fake medical certificates Medical certificate was a prerequisite for admission to institutions of learning.

Despite them coming from different locations in the country the students admitted that they had not been asked for a sample for investigation for purpose of medical exam check-up as they were joining secondary school. For some, their parents and guardians come home with the duly filled and stamped medical certificate. They had even spotted an officer recently filling the forms inside his car parked strategically on a market day. Some even harboured some remote thoughts that they too could do it given the opportunity especially during what they called the 'high season'.

There are standards and impressions that we should never compromise. How novices are inducted into the noble professions that health care is matters. For some of these youth, this was their first contact with reality of the inside of health system. It has been said that *first impression are lasting impressions.*

There is now need to focus on the quality of healthcare more closely as members of public were not taking things for granted any more. Previously, some mothers had been forcibly detained in hospitals for months over unpaid bills. When the government introduced free maternity services in public health facilities on June 1, 2013, this was with the hope of improving the situation.

Some hospitals still subjected the mothers to a bill for consumables including drugs claiming that only the delivery and the bed were free. This could run into thousands of shillings and become a demotivator of utilization of skilled assisted delivery. Such directives from county chiefs might have been meant to help mitigate certain drawbacks by the implementers but would we then say that maternity services were indeed free in these facilities.

Did declarations of free health care mean that in practice patients actually receive care for free? For all its intents and purposes it was supposed to be a *No Bill decree*, no less. Not even a registration fee (in Swahili referred to *pesa ya kadi/kufungua faili*) I suppose should be levied. It seemed like from an implementers' point of view the policy should have had free will captions like *however, the mother should never pay less than zero shillings?*

There were a few reports from undisclosed sources that indicated that some primary health care facilities covertly re-introduced 'some form of user fees' in order to cope with delayed disbursement of promised funds. Nyikuri et al (2015) study also alluded to this innovation that somehow became unofficial temporary solutions instead of stalling services in the early years of devolution.

Well, we know that nothing really was free. Everything has to be paid for by someone. In the case of free maternity it was financed through taxpayers money, borrowing or through the input of some donor partners. Perhaps it was fairer to put it to all and sundry that what this meant was that the mother would not be expected to make any direct contribution at the point of service. Such truths might make users and service providers more responsive and responsible.

According to WHO, health financing policy should include revenue raising, pooling, purchasing, and benefit package design. The functions of health financing policy needs to focus on what matters, namely the final coverage goals of universal health coverage (UHC) and improved health for the entire population.

To make progress towards these goals we must be able to measure the extent to which they were or were not already being met. Only then can the extent of any problems and their causes be investigated, identified and understood, and policies then defined to tackle them.

Universal health coverage is defined in the World Health Report 2010 and shown below. Embedded within it are specific aims which can be thought of as the "universal health coverage goals" -'all people with access to needed health services' 'quality' 'does not expose the user to financial hardship'.

In other words the first goal of universal health coverage is to provide all people with access to needed health services, namely "utilization relative to need". To improve equity in service utilization. This means that the use of health services is driven or determined by health needs, rather than other factors such as capacity to pay or geographical location.

Universal health coverage aims to provide financial protection so that the costs of using health services do not create financial hardship for those who need to use them. Payments made by people towards the cost of using health services (e.g. medicines) should not severely impact on their living standards. This includes equity in financial contributions as a fundamental goal, so that the burden of funding health services is shared fairly or equitably across society.

Given the importance of primary health care for the achievement of Universal Health Coverage, the strengthening of public sector primary public facilities was a priority for many resource constrained countries. Consider the following: somewhere in the South Rift region of Kenya, in one hospital the labour ward's service charter read such items as *admission deposit of Ksh1000*. See **section 4.9.2** of this book on Universal Health Cover.

Upon investigating the various charged items the observer realized that the service charter had belonged to its former user as a medical-surgical ward. For some unknown reason the billboard had been left intact.

But even after bringing the matter to the attention of the in- charges, the service charter remained in place some more. In yet another hospital, the maternity unit had not bothered to update the service charter in line with the new policy 4 years down the line. The same thing happened, when this anomaly was pointed out to those concerned the old service charter remained in place for -? (may be it still reads the same!). Who will rid the health sector of such lassitude? Or maybe it was not lassitude after all.

Facility strengthening required an understanding of the priorities and concerns of those who work at the interface between health systems and communities, including facility staff and managers, through tracking how they were involved with and affected by policies and interventions as they unfold over time (Nyikuri *et al.,* 2015).



Pic: Screening & Triaging of clients in one of the County Hospitals

(Courtesy of: *Community Eye Health*, Vision 2020)

Despite the premise, a 'well meaning' sarcastic reception from a columnist writer[28] had met the introduction of free maternity services (see **Gesture must shine through** below). Given the state of physical disrepair, the chronic shortages of staff, drugs and non-pharmaceuticals and equipment at some of the public health facilities, the commitment of health care workers often seems little short of heroic. There is a limit to the quality of service that even the most skilled and dedicated staff can provide in the given circumstances.

Gesture must shine through

> *'...maternity fee got scrapped. What a blessing! Why charge a poor mother to give birth when you can offer them free services in the dirtiest and most pathetic of conditions? In between the remuneration of nurses and the missing drugs and slimy wards in public health institutions, the radiance of such gestures must shine through.'*

It is easier denounce the above statement as reckless, but just a minute! There might be some iota of truth. There were in this age and time certain labour wards and minor theatres that could be described as unsightly either because there were old stains of body fluids and, some observable degree of the surgical environment contamination. What more could there be?

As part of World Bank's sactioned structural adjustement program, the year 1989 was the genesis of cost sharing in public institutions in Kenya. Severe government budgetary constraints led to the introduction of user fees for several sectors. In the education sector this included scrapping - student's monthly stipend otherwise known as 'boom' in tertiary learning institutions and the introduction of 'pay as you eat'. In the health sector; outpatient and inpatient care at government health facilities introduced cost sharing.

For children under five and some specific ailments, an exemption from fees was

introduced. In 2004, the Ministry of Health reduced the user fees in health centers and dispensaries to minimal levels in the "10/20 policy": patients pay Ksh 10 at dispensaries and Ksh 20 at health centers.

These user fees accounted for about 3 to 5 percent of the Ministry of Health recurrent budget and 30 percent of the recurrent budget for operations and maintenance. Revenue-collecting health facilities were allowed to retain 75 percent of revenues for improvement of their facilities, the remaining 25 percent of the revenue collected went towards financing promotive and preventive services in the district.

At some point the Health Sector Services Fund allowed the health facilities to retain 100 percent of revenue collected, generally used to buy medical supplies and hire casual staff. This allowed hospitals are able to contract cleaning and security services among others(Luoma *et al.,* 2010) which in turn contributed to the improvement of quality of services delivered. However, many patients continued to seek waivers due to inability to pay for the services with several studies pointing out the negative impact of user fees on utilization of health care services in Kenya. On the other hand users may feel that due to the fees they paid they could make higher demands upon the health workers.

Outsourcing of public sector work was driven mainly by a desire to cut costs. In outsourcing, part of the organization's production or service process was discontinued and transferred to another party (see **Improvising casuals** above).

However, the *Kenya Household Expenditure and Utilization Survey* (2007) estimated that about Ksh 7 billion was actually paid to public providers, compared to the reported Ksh 1.5 billion for the same period. This survey finding suggested a level of under-the-table revenue collection - or outright theft of funds. This finding was confirmed by the huge increases of revenue collection in hospitals that had since installed a computerized revenue collection system. Hospitals became an easy target when budgets needed to be scaled down or money needed to be transferred to fund something else.

Once revenues have been raised from health care related service delivery, it is assumed that they should be subsequently pooled, they are then used to purchase health services. Doing so in a way which furthers the objectives and goals of the health system. But as far as many county authorities were concerned hospitals were just another revenue collection point, but then wasn't this the law?

[28] *The Standard*, July 1, 2013 'Gesture must shine through; in Crazy Monday, Bulletin pg. 11

Improvising casuals

For some reasons the public service downsizing of the early 2000s took care of the noncore staff included subordinate and domestic staff. While majority opted for the early retirement 'golden handshake' package or left service after attaining retirement age, others were retrenched. The few remaining were redistributed. All these without replacement.

As mentioned above, it became necessary that hospital managements outsourced housekeeping services from private firms who in turn brought their staff. In the given circumstances they did a commendable job of keeping the hospitals clean, and actually they were much 'cleaner' compared to before the outsourcing times.

However, most were underpaid and exploited. They were overworked in terms of workload and working 12 hour shifts. Borrowing an example from a particular sub county hospital's post natal ward. This one female staff reported for duty at 6.30 am, scrubbed the floor; collected and served patient's breakfast; did the sluicing work; prepared and took dressing packs for sterilization; made 10 0clock tea for clinical staff's; mopped the floor in between; went to collect nonpharmaceutical supplies from the stores; collected and served patients' lunch and 4 o'clock tea etc.

In yet another county hospital labour ward it was an extreme. Sometimes cleaner would come once a day, then take off to clean elsewhere. Then leaves with a caption mtaji-sort everyday Sheng 'you can sort out yourselves' or else you do not have to keep on looking for the cleaner every time you need them or do the obvious - the nurse does the rest of the day's cleaning.

Generally these casuals were not adequately supervised. Many were not well versed with infection prevention and control practices (IPPC). They rarely got proper personal protective gear or working tools. If one happened to observe some of them as they worked some things they did were nerve chilling. These are just but a few : handling of sharps was wanting. Some had been observed mopping rail guards and other tops surfaces with same floor mop. Others squeezed the improvised mop blanket with their (albeit gloved) hands. It was not unusual that they took gloves from *one* house to another thus contaminating surfaces and handles.

It would be a wise guess that (just like a good number of public hospital staff) they were not immunized against Hepatitis B among others. Obviously they earned no risk or extraneous allowances. It became apparent that the welfare of this impoverished lot was something neither the hospitals nor the firms worried much about.

One private firm director revealed that the annual (renewable) contract was pegged at Ksh15, 000 per staff hired to the hospital per month, they in turn paid Ksh 13,000 monthly wage. He admitted that contracted service providers could not be expected to effectively apply the optimum methods of cleaning and sterilisation need by hospitals. They lacked the required capital and materials and those hospitals should assume that responsibility. There was also a high staff turnover. Perhaps we might have expected that outsourcing saved money but perhaps led to lower standards in terms of hospital acquired infections etc.

Decisions as to which firm to procure were shrouded with philosophical or political machinations rather than the objective of which one made both quality and business sense. Certainly, outsourcing in the health sector could enhance service delivery as evidenced by the case of The Nairobi Hospital (Ichoho, 2013).

The Public Finance Management Act 2012) took away the hospitals' freedom to retain, bank and spend collected revenues at source. The law required that all collected revenues had to be pooled to the County Revenue Fund (CRF). It had been observed by various disappointed health services managers that the strict financial law put in place to curb on corruption was now preventing spending money on hospitals.

Account user fees collected and disbursed to health facilities would, under the devolved system, go into an account managed by the County Treasury. This redirection of funds would reduce the ability of health facilities to purchase consumables supplies or hire support staff. 'We cannot sort out day to day maintenance issues, drug stock outs…we cannot respond to emergencies that require spending'.

'Ring-fencing the budget for health at every level, and ensuring that there was prompt release of funds when needed was not easy'. One hospital in Nyanza region collected on average Ksh 2m per month as user fees yet it had its electricity disconnected over a Ksh 700,000 accumulated debt.

In several counties all revenue from all sources (including health facilities) had to be banked in one central county account. Hospitals were required to place requests for needed goods and services which were then procured and paid directly the county government. It then awaited the appropriation committee to make decisions as to what would be their priority activities and projects, but the money was rarely reimbursed in full.

One county health executive vouching for the needs of the hospitals expressed her frustration this way, "*I loathed the unnecessary irritation of begging and nagging for money that is supposed to be released with minimum fuss".* Barasa et al (2017) concluded that by increasing the autonomy of county hospitals would improve their functioning.

It had been observed that majority of the counties were not generating significant internal revenue. An example is one or two that were reportedly doing less than a quarter of what defunct local authorities in the same county used to collect before devolution. This meant that they were like 90% entirely dependent on allocations from the central government. If there were delays in disbursement programs and services suffered as counties' business' ground to a halt.

This was one of the bottlenecks health managers faced in Kenya (Barasa *et al.,* 2017) [see **Recentralization within decentralization** below].

Recentralization within decentralization

'Devolution had resulted in a substantial reduction in the autonomy of county hospitals over th five key functions examined. This resulted in weakened hospital management and leadership, reduced community participation in hospital affairs, compromised quality of services, reduced motivation among hospital staff, non-alignment of county and hospital priorities, staff insubordination, and compromised quality of care'.

'…we collect a lot of user fee revenues, why can't we use that money on this and that. And you see if you can't use it even to at least do some maintenance within your departments then of course the staff who are working there get demotivated. They wonder why they are bothering to help generate income if that same income is not coming back…'

'…it is meaningless because procurement is done by the county health department so here in the committee we just talk and talk but we have no real authority'. (Barasa et al., 2017)

Refocusing away from this generalisation approach to health requires strategic thinking and careful consideration by all concerned parties to ensure allocation of pooled funds (plus additional funds) to providers that deliver health care goods and services. Simple line item budget allocation based on the previous year's budget, and increased slightly to

account for inflation was not adequate.

Each county was unique and each facility so. Allocating stuff and staff without checking whether they were needed was wrong. At the back of everyone's mind it was good to ask ourselves this question – Do we have ways designed for protecting funding meant for primary health care services?

Allocating of funds ought to be based on of information such as: which services should be delivered as a priority, based on a health needs assessment of that population; how the staff and facilities delivering the services are performing; quantity and quality of services delivered among others. Were there incentives that contributed to improved performance previously and how can we enhance these as well as promote growth?

Not just basing on number of beds in a hospital but allocating funds in a way which actively promotes improvements in service quality and efficiency. Factors like how the general population in an area access these services needed to be accounted for e.g. was it a rural or an urban facility or was the much of the funding going to high-cost but low-priority services?

The existing burden of disease in terms of : age, gender, geographical distribution; how well interventions are currently delivered; how much money is currently being spent on different health services; what were the spending projections say in the next 2-3 years? In the budget were there reference pricing for goods and services and were they cost effective? Do we have budget control on the overall level of spending? Respond to changing needs and shift resources accordingly and allow some degree of autonomy.

It had been observed that generally increased hospital autonomy had the potential to result in, among other things: autonomy to reallocate resources appropriately; greater efficiency; improved quality of services; expanded accountability; increased

understanding in communities about how hospitals operate and serve the communities; and improved equity in distribution of the services. County governments should therefore be encouraged come up with legislations that gave hospitals greater control over resources and key management functions within the context of devolution.

Perceptions of the public on caring

Perceptions that the public have on what caring matters to them and ought to be an awakening call to the health care providers. This was one of the key observations in an earlier study by Ovretveit (1992). However, Ovretveit was careful to note that patients' views on the quality of health care might differ from the views of health care professionals, managers, and policy makers.

My take on this is based on the experiences shared by some people I interacted with in emergent convenient encounters below; only the first one is paraphrased while for the others representative quotes are captured verbatim (albeit interpreted from original dialect):

> I met an elderly lady at her home who had just been discharged from one of the elite hospitals in Kenya which considered itself as 'caring', but she alleged she did not get her teeth brushed, her hair washed, was not even assisted to clean her hands before a meal for the entire two weeks she was in the hospital.She did not experience 'care' in this class hospital where the nurses prided themselves as being 'caring'. While nurses might have seen themselves as 'caring', they forgot to

provide 'care', commented a renowned nurse educator [29] on a discussion on caring. Nurses might have felt 'care' as an emotion. This unfortunately did not translate to the patient feeling they got 'care'.

'....sorry to say but some of the general wards had this *faecal-like* smell right from the door', added another respondent.

'It had increasingly become an open secret that in some level six hospitals the only hope for quality care including patient feeding,wound dressing etc. was getting into the private wing/amenity'.

Touching base with some rural folks out/in a hospital environment, they had this to say concerning their less than desirable experiences with health care services they received:

For those who reported utilizing public health care services, they revealed that they normally made hard choices to suit their needs as seen in the statements (see Testimonies 1-6 below).

Testimony 1

'It is better that I go to another hospital which I do not know anyone instead of going here in the neighbourhood if so and so is working there' (a youthful resident).

- an informant had a sarcastic view of government sponsored facilities as illustrated in this statement:

Testimony 2

'Since when did you visit a public dispensary?' (Another youthful resident).

The impact of waiting time before being attended to were considered equally important as shown in the following excerpts,

Testimony 3

'The senior clinician has not arrived yet so we all have to wait in a nearby field sunning ourselves, and when he comes no one in particular announces but there will be a commotion, a struggle as everyone jostles for position in the queue, he might just see a few patients and then slip out through the backdoor. Even those who had gone inside will have to leave after some time, surprised and asking themselves where the doctor has disappeared to...' (An elderly lady attending clinic for a chronic condition).

Some reported that the health care providers did not feel it was important to let the clients know what was going on as depicted in this statement,

Testimony 4

'To people waiting on the queue, whenever nothing seems to be happening and they are not being attended, then the staff have gone for tea break' (a young mother who had brought her baby for regular immunization). We don't mind waiting as long as everything is Ok … as long as we know what is going… on (Two young women shared).

[29] https://www.researchgate.net/profile/Elsabeth_Jensen/

Some of these might be were perceptions about inefficiencies of staff or should we say users of technology; for example anecdotal evidence showed that it was not always felt from the customer's point of view that online registration and pay points were more efficient than the manual system if they had to wait longer or it did not reduce the bureaucracy.

When asked whether they raised their concerns with the concerned officers, there was some kind of complacency or recollection as seen here:

Testimony 5

'There is a possibility, in some dispensaries, some of the staff might or will get offended if you make a complaint. They feel as if they have been accused. That is not good since you will still need to come next time for …' (a middle aged woman). When asked if they knew of any benefits of raising a complaint with the supervisor, some mixed reactions of apathy and realization in the following:

Testimony 6

'They feel irritated. But we insist on them and tell them look … this is for our own good, so try and correct mistakes' (two middle aged men shared).

The point of being informed about what is going on is very important to clients and their significant others, even if they will not do much with the information, it's about them. A story line 'death after delivery ' run in the media of a man who lost his wife after she had given birth due to severe bleeding[30].

> Everything had been alright as he left the hospital that evening. He had even seen the new born baby girl. Only to come back the following morning to be informed that his wife had died. One thing he wished was *'why did they not call me to tell me my wife's condition was deteriorating? At least I should have known.'*

A Maternal death incident should be treated with utmost seriousness, the policy often was that a team of stakeholders should conduct a mortality audit on the case within hours but not later than a day after the death to establish the cause of death, if it was preventable and what could have been done better to save the life of the woman.

Unfortunately, many a times for resource constrained settings the occasion for debriefing /post mortality audits were aimed at 'covering the tracks' and so obviously the main stakeholder, the patient's significant other was neither involved nor informed of the findings. The reports were filed upwards. This is a slippery slope argument that could attract a lot of currency. Let's consider another incident (see **Did they really lack everything** below). A previously healthy adult dying of complications of a non-full thickness, non- inhalational 12 % burns for what could be less than optimal care was not excusable. On the other hand early referral should have been possible but was not done. But again what would be the indication for referring from that level of a facility, could they *boldly* indicate heating facilities.

But then we have referred for much less convincing reasons. Still it was better to refer than to lose the patient in such circumstances. Heating facilities remained an ongoing

limitation to quality care in many labour wards and newborn units (or rather wherever they were needed). Quite often these incidents go unreported and undocumented. It has not been said often enough what implication these could have on public safety since the quality of health care was certainly much less than expected in this era and age.

Did they lack everything?

The following story whose identity and place has been changed for ethical reasons was shared by a 4th year nursing student two years ago about a middle aged man who had sustained 12% burns after accidentally falling into boiling water. Affected areas were the left hip region and the left upper limb. He got immediate admission to one of the public hospitals.

The patient remained cognitively good and could get out of bed when necessary. Eight days later the patient became delirious and died from what could have been: sepsis, hypovolaemia (no active hydration was taking place or else it was erratic), hyperkalaemia (Potassium level of 7mmol/l on day 7 was corrected with bolus 50% dextrose and insulin).

No real hyperalimentation efforts worth mentioning. Hypothermia could have been real. A space heater was difficult to come by for 7 days since admission. It also happened that this was during the coldest month of the year. By the time a heater was brought on the eighth day it was too late.It was notable that this side room did not have 1ight at night either, no electric bulb or fluorescent tube anywhere on site. Getting warm bathing water was not easy either. Getting clean beddings to change the patient was another challenge. The hospital relied on sunlight to air dry all its linen and had not known any other mode of drying. The caretaker did much of the care including applyingDermazin cream®.
(Story used with permission. Some circumstances changed to protect identity).



Pic: An entirely weather dependent mode of drying hospital linen including operating theatres linen (Photo courtesy of pan Afican anaesthesia symposium Nairobi 2010)

[30] NTV PM, 20hrs 24th Jan, 2015

Public relations departments may often be put to task to do damage control in what had come to be referred by a section of the media as crisis communication strategies. Nevertheless, it is also fair to consider that while patient/public feedback is usually valid, there are times one needs to listen politely while an unreasonable family or patient makes an unfair accusation against staffs.

Some allegations may be unfounded or outrageous, at times made in an attempt to get even with a staff or to have their hospital bill waived. As a health care provider you would need to have a stick-to-it resolve that no matter the temperament or behaviour of your patients you are determined to provide care with a caring attitude and a loving heart (see **Confessions of a hospital administrator** in Chapter 17).

Patients and family members do and will continue to write letters to editors and post on social media. Trying to run ahead of social media might be hard but making the correct judgement on the part of health care provider is needed at all times. A balanced inspirational manager will need to learn when to take sides.

Donna Algase (2013) the editor of *Research and Theory for Nursing Practice* observed that some of these viewpoints by the general public are borne of a pretty narrow understanding of nursing and its potential to affect the health care delivery systems. Consider these comments about nurses from Algase's (journaling at one point as a patient herself) concerning patients suffering from various skin conditions:

> Nurses' acceptance of their various, some unsightly, skin conditions; respectfulness of our privacy and dignity; extensive knowledge of each type of treatment; willingness to share knowledge concerning skin care pertaining to our conditions; careful and gentle handling of painful or tender areas; patience with our setbacks or need for repetition; and attention to our physical comfort…
>
> Variations in the techniques that each nurse used in applying my treatments; how they attempted to adapt treatments to my uniqueness, such as my size and preferred activities, freeing my fingertips so I could type; and how they each built on what another of them had learned about me (Algase, 2013).

When Tatano Beck (2004) analyzed stories of 40 mothers who had experienced post-traumatic stress disorder as a result of giving birth, four themes emerged from data analysis:-

1. To care for me: Was that too much to ask?
2. To communicate with me: Why was this neglected?
3. To provide safe care: You betrayed my trust and I felt powerless, and;
4. The end justifies the means: At whose expense, at what price?

A Service Delivery Indicator survey (SDI) was carried out by the World Bank Group (2013) made some objective related observations. SDI, a bold Africa-wide initiative … tracked performance and quality of service delivery at frontline health facilities across countries over time. In the health provider effort category they assessed: absence from facility and caseload per provider.

The survey found that over 29 percent of public health providers were absent from work, 80 percent of this was sanctioned absence e.g. calls in to report they were sick.
Dr. Gayle Martin, SDI program leader emphasized that this absentee rate amongst clinicians was one of the primary causes of inefficiency in development efforts, yet despite its widespread occurrence, there were few measures of how often it occurred and the impact it had. Service Delivery Indicators aimed to correct that (See **The ever present trainings** below).

In concurrence to these study findings, a common observation among health sector employees in Kenya is that a good number of them use their employer's time and sometimes resources to do their own business whether at their place of work or away.

Some findings from a study commissioned by Family Care International (2003) covering Homa Bay and Migori districts, several community leaders observed that facility-based staff were increasingly splitting their time between government facilities and their own private clinics.

As a result, providers were not at the hospital, even when they were supposed to be on duty. Such absences only exacerbated the already-severe staffing shortages at health facilities. "You go to hospital, and you find doctor is not there, but in their private clinics, and it is working hours…"

When quizzed a little why these findings were likely to be the case, the responses were heartfelt and very real. That is, when one considers a comment like the following by one clinician '…ni pa kula na kunyua, na kujulikana. Huko nje mtu ni chukua chenye unachukua…' Paraphrased from Swahili *I need this place for my upkeep, and also build a name. Out there you never know*, *often one lands on something*. This might be construed to mean that keeping a public job is prestigious due to job security. Might be one gets to recruit a few clients for themselves and referred them out there in private practice.

It could also mean the clinician is less committed while in public service compared to private practice. After doing the bare minimum (usually only a ward round) they left to earn more money elsewhere. It was hard to justify absenteeism on one hand and complain of a low doctor to patient ratio on the other hand. But then, many good doctors were doing their best in bad conditions of work in our public hospitals.

Perhaps still there was perceived competition out there, trying to measure up in terms of quality care, but never mind - there was always a fall back (the public hospital). While a lot of people would be interested in the issue, few including policy makers did anything about it. Hopefully, it adds another pebble to the avalanche that will be needed to bring reform to the health sector and how we got to this point.

At every opportunity it became normal in some settings to operate at bare minimum, if we could get a valid reason to do so – a national holiday happened to be one of them. Add the breaks that some establishments gave their staff then the time for being away from work becomes a lot.

Consider the following line of thinking. Ugandan's Commissioner for Revenue was among the first authoritative figure to admit on 1st of August, 2016 that the many national holidays in the past one year did infact lead to less taxes being collected: *Some Uganda Ush5b (approx. Kshs 150.4m) in taxes, was lost to the Uganda Revenue Authority (URA), each time Uganda had a public holiday. In an exclusive interview with The New Vision,*

the Chairman Board of Directors URA Dr. Eric Adriko said, in their budget proposals URA had recommended Government looks into the issue, by reducing the number of these holidays.

Typically during a run up to a general election, Kenyans tended to keep away from normal social and economic activities for as long as it took to declare the winner. That was our social order, doing literally 'nothing' else except watching and waiting indoors. In 2017 the cabinet secretary in charge of public service firmly instructed them to resume duties 4 days after the election, but then, this was Friday, and moreover the presidential elections were yet to be declared.

It was unlikely that any meaningful response to this order would be realised until after the weekend. That meant 7 days or more if you add a time out that could include a period before the election date. But more importantly if the election got contested or turned violent this period was uncertain. Election violence (pre or post) has been addressed variously inside this books. When one adds the strikes to the holidays then we have hardly worked in 2017.

*That's about it for every other African coun*try, more or less. What else could be adversely affected by holidaying? Health care obviously was one of them. Health care is a custodian of life. It being an essential service notwithstanding, many people in resource constrained settings knows for a fact that less than optimum care to nil care was offered during odd hours, weekends and holidays.

Vital deliverables have to wait and appointments cancelled, why? An upcoming long weekend, *everybody should be able to understand*. The bosses pack their bags and bolt out (exit faster than a nurse clocking out after their shift) either hoping nobody calls them back or deliberately become unreachable. The systems sort of gradually glide to a halt.

Then we have to start all over when we come back. Our systems have yet to cope with these shocks. Why not make our systems work? There was need to deconstruct these social order if we were to realize meaningful development.

The ever present trainings

'The good thing about rurals' is that there are plenty of workshops and trainings. You are in this and that other one, it's kind of a ka-lifestyle'.

'Some people you do not see them much at work, they are away for this and that other training, seminar, workshop etc ...'

Some trainings for county staff come from national government on short notice, county may not be informed on time, and service delivery might suffer.

'You go for two seminars, phew! The month is gone, just like that'.

'Some come with good allowances and chance to travel and get accommodated in posh hotels...'

'The guys who organize and do invitations, its big time, it's hard to dislodge them from those seats, these are powerful positions'

[Shared on different occasions by healthcare providers]

This author admires Prof PLO Lumumba ideals and from time to time has shaped his opinion on governance and leadership. In Lumumba *et al.,* (2014) he described a typical Kenyan civil service workplace culture through the escapades of the main character 'Matata' and many others in the novel *The Public Officer*.

Institutions charged with fighting corruption in terms of: oversight, investigative, prosecution roles seemed not to take clear decisive, and categorical actions of making office bearers be held into account. Prof Lumumba was a former chief of the Anti-corruption body in Kenya.

But anti-corruption agencies needed some positive impetus instead of being misused to settle scores between those trying to protect their trappings of power and wealth. The role of the citizenry, civil society to graduate from personality politics to issue based one with zero tolerance to corruption.

In 2016 Corruption Perception index, Transparency International (Ti), a global anti-corruption watchdog, ranked Kenya at 145 out of 176 countries. The Auditor General's interim audit reports had time and again uncovered misappropriation of taxpayers' money through forgery, double payments, illegal budgets and overspending. It was estimated that the country lost Ksh 300b per year which was about a third of the annual budget.

Were there no institutions to fight the vice and systems to ensure it did not happen in the first place? What about anticorruption czars? Concerning corruption and work ethics in the government a former cabinet secretary (CS) for devolution had this to say 'systems and programmes are as good as the people they serve'(Forbes Woman Africa Magazine June/July 2014).

Taking the high moral ground, a former governor had installed a brand new power generator worth Ksh 2.5m that had been procured by the county into his hotel. Of course to porovide power in case of power blackouts, he denied stealing it and the case was under investigation. The matter had been all over the media in November 2017. Suppose it was meant to be a standby power source for a health facility? [*www.the bigissue.com*].

The former governor claimed that the generator had been brought in during a seminar for his county staff in the hotel during a time that there was a power blackout, some years back.

Something else that needed to be mentioned here was the question of doing business with government. Goods and services that would otherwise only fetch a modest profit or mark-up/average wholesale price at market rates were procured by the government for even up to 300% profit. The margin of error estimate were usually way above or below the ten plus or minus. This became more evident when figures were released to the press (one such release had Ksh 150m, 180m, 330m for the same item).

For reasons best known to the parties involved the margin of error could be any range depending on who released the figures and of course to whom they were released to. A house that would ordinarily cost Kshs 5 million to construct costs 5 times or even more when it was done for or by the government.

Some of these substantive concerns were raised by Hon. Alice Wahome, the Kandara Member of Parliament [31] while contributing to The Public Procurement and Disposal (Amendment) Bill, 2013 sponsored by nominated MP Hon. Johnson Sakaja on 19th February 2015. She added, "it is unfortunate that public procurement officers had monopolised government tenders…They have locked out… who had no networks to

clinch contracts," The bill sought on a law that would see 30 per cent of tenders reserved for the youth. It had since been passed into law (BillTracker).

If we took it that the goods being mentioned in the above discourse were drugs, non-pharmaceuticals or medical equipment the cost of this exploitation was a direct burden to the tax payer and impacted on the quality of health care delivery. The law required that there be public participation in procurement of public goods and services although it did not spell out the modalities. It might be understandable (although disputable) that the nature of turnaround time would dictate the extent of public participation, as in emergencies resorting to direct procurement.

It was not surprising then, that when Archbishop Wabukala took over as the boss at the Ethics and Anti-corruption Commission (EACC) in early 2017, his first assignment was to stop cartels ripping off Kenyans by overpricing medicine and medical equipment. During the briefing parties (Ministry of Health and EACC officials present) observed that there could be certain loopholes, avenues and opportunities for corruption that might have been exploited. This created huge cost burdens that denied many access to health care. There was need for policy strengthening and efficiency in the system to reduce wastage.

Moreover, this type of corruption had a way of fighting back, presented raw competiveness to law abiding outfits because they often enjoyed patronage from people in vantage positions. Attempts at dispute resolution or court processes involving these elements were generally lengthy.

Backlog of court injunctions forestalled many such processes. As such they fought efforts to build credible institutional structures. In as far as ethical principles are concerned there were many aspects in accountability that could not be sanitized through a court process

Unregulated medicines

In general, a lot of counterfeit and substandard medicines somehow made it to the Kenyan market. An organization called Action Against Counterfeit Medicines (ACIM) had found out that this was rampant in many African countries. These included a wide range of products: antimalarials, anti inflammatories, antibiotics, analgesics, gastrointestinal medicines and surprising anticancer drugs.

Kenya Association of Pharmaceutical Industry (KAPI) commissioned a study in June 2017. The nationwide market study on the degree and quantity of counterfeit and potentially dangerous medicines in Kenya's retail pharmaceutical market. The study was carried out by The University of Nairobi's School of Pharmacy. The results released in July 2017 showed an 8% prevalence of unregulated medicines.

These medicines were not sourced through established channels and through unregulated imports. The KAPI study would form a basis for surveillance, enforcement interventions in conjunction with customs' department, Ministry of Health and other related stakeholders. They would make the exercise more regular. They would also engage consumers through education as well as whistle blowers. The Anti-counterfeit Agency (ACA) of Kenya netted goods worth Ksh millions every other time.

[31] http://www.businessdailyafrica.com/30pc-of-tenders-reserved-for-youth/-/539546/2204192/-/f4cx90z/-/index.html

Press Release

Sealing Corruption Loopholes in Kenya's Health Procurement Systems Written by Transparency International Kenya . Media Statement http://tikenya.org/index.php/press-releases/412-press-release-sealing-c... Nairobi, Sunday, 24th April 2016

Modified with commentaries 'How corruption drives up Medicare costs in Kenya' by H. Irungu, S. Ochola and S. Kimeu Updated Tue, May 17th 2016. *Mr Houghton is associate director, Society for International Development. Ms Ochola is deputy executive director, Kenya Ethical and Legal Issues Network. Mr Kimeu is executive director, Transparency International - Kenya.* The law on public procurement governs purchases in all State organs and public entities in Kenya.

It states that standard goods, services, and works with known market prices shall be procured at the prevailing real market price. The health Ministry's essential drugs list sets out the importance of ensuring that essential medicines are valued at the lowest price possible to make it affordable to as many people as possible.

This commitment is threatened by corruption in pharmaceutical procurement. The market prices index (MPI) is a central pillar of the government procurement system. . It gives price guidelines for goods and equipment to the public procurement agencies. However MPI sometimes has major and unexplainable fluctuations in the cost of essential medicines and equipment.

They found bizarre anomalies between the costs of medical drugs and equipment in Kisumu, Mombasa and Nairobi. On average, they found that prices were inflated by between 30 and 300%. Taking the lower figure, this could amount to Kshs 1.1 billion shillings.

In the sampling under review, the costs in Kisumu or Mombasa were up to 500 percent higher, even though most of the equipment was imported through Mombasa. A delivery bed for instance, costs Kshs39, 357 in Nairobi, Kshs 49,000 in Mombasa and Kshs 114,500 in Kisumu. Ciproflaxin® (original) was priced at Kshs 635 in Nairobi, Kshs 2,026 in Mombasa and Kshs 975 in Kisumu. Inflated prices for medical drugs and other supplies further drive up the cost of healthcare, alienating a majority of Kenyans from accessing basic health services.

The quality and accuracy of the market prices index is thus critical in eradicating corruption. The Society for International Development, Transparency International-Kenya, and the Kenya Ethical and Legal Issues Network sought to establish the accuracy of the market prices index in comparison with local and international market prices.The findings of this study are published in a policy brief titled Sealing Corruption Loopholes in Kenya's Health Procurement System.

The report recommended that: 1) The Ministry of Health should institute its own review of the implications of the MPI,

2) The Ministry of Health should develop and implement a medicines' pricing policy for greater transparency, regulation and uniformity in pharmaceutical pricing.

3) Public Procurement Oversight Authority (PPOA) should overhaul the Market Prices Index and publish the names and backgrounds of the anonymous "renowned researchers', their selection process and period engaged to produce the Index.

4) The director of public prosecutions should surcharge public procurement officers and other officials who may have facilitated significant losses through the purchase of inflated goods and services. (Seemingly the incentives to misappropriate existed in the system since cases were allowed to drag on and on for years, by which time the culprits have had time to spend the proceeds. The law apparently serving the culprits more and less the victims)(- *addition mine*).

5) National referral hospitals as well as county hospitals must publish all health-related procurement contracts for each financial year on their websites and in the media for public scrutiny.

6) The Ethics and Anti-Corruption Commission, Directorate of Criminal Investigations and the Asset Recovery Agency should review and institute proceedings against those found culpable of using the MPI to inflate price procurement. The agencies should recover money from companies that supplied above price reference lists through collusion with public officials.

7) The Office of the Auditor General must pay special attention to the loophole that the Market Prices Index has created for financial inefficiencies, fraud and theft;
8) The best cure is Kenyans coming together to keep the costs of essential medicines and equipment as low as possible by scrutinising health procurement, and demanding transparency and uniformity in pricing. Since the public pays the ultimate price for corruption in the health sector – death. *(Used with permission)*

*[this author] M*ore often than not, whenever the auditor general raised some queries over a matter it became sensational rather than being predictive. Usually it just fizzled out of public limelight until some other audit report emerges.

It was unfortunate that in many resource-constrained settings, successful corrupt free organizations had more to do with management capabilities of persons vested with responsibilities to manage and not any superior systems in place. Individuals, networks can fatigue but institutions do not. Therefore it was better to fight to have strong institutions, systems, frameworks, models etc. Strengthening them included funding them deliberatively and affirmatively to enable them to do what they were mandated to do.

The role of political goodwill in all these was paramount. Even though this book will highlight this matter time and again as it became unavoidable, its scope was limited. The reader might wish to explore better references into the topic of integrity.

The introduction of performance contracts and the citizen service charter, which had been cascaded at all levels, was expected to further improve governance and better engage communities in health sector service delivery. Yet several sources indicated that the public service in Kenya was dogged by its inability to decisively discipline staff.

It could take like eternity to arrive at a definitive disciplinary action. Errant staffs continued to be in service, employees who ought to have been dispensed off with continued to draw a salary despite being unproductive or having committed some serious offence(s). They continued to be numbered among the ratios. Rarely did anyone lose their job. It was a costly matter to the service, clients and other members of staff suffered as a result.

The following best case scenario - 'Disciplining of themselves by themselves' might highlight some of the salient points (See **Punitive measures** and **Crossing the line** below). Based on the facts below, what would have happened in the best of centres? The following were excerpts from the discussion:

Punitive measures

…We used it once; we did a 'nil per oral' on one of the easy-going, non-productive member of the nursing team. She was on disciplinary with one more chance and there was nowhere else to post her so they brought her to us at OPD (Out-patient department). We decided not to allocate her any duties, not to consider her as an extra pair of hands or brain for that matter, we assumed her. It did not matter whether she came or spent the day in her garden.

After all she previously used to tell all who cared to listen that as long as she was not on night duty she would be available for other errands whenever needed wherever else (outside work off course). This went on for like two months. Initially she pretended not to care a hoot, and then

she tried to make inroads, nothing doing. We were as intact in our decision as we could be. Our immediate supervisor was with us.

By third month the message was clear to her, she did not matter, she did not count, and we could go on like this forever. Finally she did what we call looking to 'make a truce' she came carrying a green branch. If someone does that in our society you accept that person back into the society if they were outcasts, during conflicts or war etc.

She got reformed and became one of the reliable members of our team. This was over 20 years ago, never remembered it until now.

(Recounted by one senior nurse). Compare this with a rejpinder to above from a nurse in the US

Crossing the line

Sending someone to 'Coventry' a metaphor for no-one is to speak to this person for at least a month - can be devastating. There were diverse reactions: Do you fear the line may be crossed and that peer pressure turn into bullying? This might be labelled as outright bullying or cattiness. It's
interesting to me to learn why or when people think its okay to blatantly go against the policy. It
would seem unless the individual has a great deal of self-awareness and self-responsibility the lesson will be lost. For me it's step up or step out-period! She would have been fired on the spot.

If the person is not performing up to expectations on a unit is it our responsibility under our code of ethics to hold that person accountable. Such a worker would not be tolerated, but would simply be terminated (fired) by the organization. The details of the job description would be clear, and if the worker does not perform them, then she cannot retain the job.

3.2 Meaning and Measure of Patient Satisfaction

As with almost every other service delivery sector: - education, security, retailing, telecommunications, banking, media, hospitality, repairs and maintenance etc., the concern for quality is often inverse to quality per se`; often being addressed only as a result of consumer feedback. Quality can be a difficult concept to define by consumers of a service, and sometimes it takes great indignity or gross negligence to recognize that quality was lacking.

Oftentimes people become most acutely aware of quality of health care when their lives and that of others were threatened by the acts and opinions of their care provider or by the circumstances of their life. We may struggle to define quality, but when we look at how people treated others in certain incidents, we know quality of service was poor.

Sometimes abstract concepts pertaining to quality (as covered in Chapter 1) were hard to define, but we know them when we see them. They come into clearer focus during our interactions with others as they share different versions and testimonies concerning health care, be they positive or negative.

Service provision quality was constrained by inadequate standards and lack of enforcement of existing laws while quality continues to be hampered by the lack of accreditation for public facilities (Luoma *et al.,* 2010). That might be the reason why Quality Management Systems (QMS) was an elusive concept that was a much sought after accreditation by many institutions. Some of its tenets being: standards, quality of service, customer satisfaction, customer feedback and continual improvement.

In some developing countries, studies of patient satisfaction and experiences with health care were carried out regularly, and the results made available to the public together with other indicators of health care quality (Waju, Challi and Morankar, 2011). Patient satisfaction due to care given was a critical outcome because it influenced adherence to treatment, health services utilization and general attitudes towards the health care system.

There were notable differences between patients' expectations and what they actually received in terms of accommodation, availability, patient-provider interactions, health information, and communication, which were identified as being of inadequate quality. Significant effort is needed to improve the quality of patient care with respect to these particular aspects from the perspectives of patients. These were the findings of a study on TB patients by Eticha, *et al* (2014). As such, consumer feedback alerts managers to users' needs, perceptions and concerns, identifies areas of service failure, and enables the evaluation of improvements as they were implemented.

The dimensions of quality that relate to client satisfaction affect the health and wellbeing of the community. Patient satisfaction was found to be one of the factors that influenced whether a person sought medical advice, complied with treatments and maintained a relationship with the provider/health facility (Brawley, 2000).

Human factors such as compassion and respect given to patients by care providers were rated "poor" especially in the hospitals in one Ethiopian study (Waju et al, 2011). In addition, the patients' privacy keeping practices by care providers was reported as poor at all levels covered by the study. It was especially important to take into consideration the challenges of certain interventions in terms of cultural sensitivity. (See **The cholera treatment unit** below).

The cholera treatment unit (CTU)

Cholera is a notifiable highly infectious disease transmitted by faecal-oral mode. The cholera outbreak has to be contained at source and no referral whatsoever is recommended. The cholera treatment unit acts as an isolation ward where patients are managed in terms of rehydration among other care.

Not many years ago, there was this particular CTU, a large tent donated by a world renowned health organization to a hospital in a cholera prone zone along Lake Victoria. There had been reported 200 cholera cases from March to May that year involving mainly fishermen, women, elderly and children. The mortality was reported of about 7 people.

At some point there were quite a number of these inpatients in the tent. 'There was absolutely no privacy - men, women and children shared the same space, no screens, nothing! Rectal swabs would be done in the open as other patients watched, not to mention the effortless continuous diarrhoea, the cholera beds were so squeezed'. Off course some patients were on the floor since there were not enough beds for all of them. This could be described as less than human conditions. 'Imagine a father in law being done a rectal swab while the daughter in law was watching, this isagainst African traditions' commented a concerned staff who shared this story covertly.
(The topic on Cholera is described in Chapter 3 of this book)

The Waju study further indicated that there was a general agreement that "quality" should be assessed from the viewpoints of major stakeholders such as users, care providers, payers, politicians, health administrators and against an explicit criterion, which reflected the underlying values of a given society (Waju *et al.,* 2011).

According to Kenya Service Provision Assessment Survey (KSPA, 2004), less than half (46 percent) of health facilities in Kenya reported quality assurance activities. KSPA also assessed whether facilities had a system for acquiring client opinion and feedback. The findings showed that very few facilities - only 9% had such a system … only 2 and 4% of faith-based organization and private for-profit facilities respectively elicited client opinion and had a system for reviewing it.

Uncertainty used to be a fact of life in some (if not many) of the of these public health facilities, the staff were not be sure of what they ought to do with (their own let alone) customers' feedback or an inquest into the quality of the service they gave. Indeed a study by Bukachi, Onyango-Ouma & Siso *et al.,* (2014), staff at the health institutions were reported to have made various complaints to the provincial and national levels yet did not

receive any proper explanations for the decisions taken concerning their complaints.

Boda Boda wards

The motorcycle seat taxi was a popular mode of transport across and within the east African countries, hence the name border - border or else boda boda. Initially set out exclusively as bicycles but evolved to motorbikes.

Employing almost 5 million people in the three countries. The government in 2010 zero-rated taxes for 250cc engine capacity and below bikes making them more affordable. They were sold in grocery stores; supermarkets etc. and apparently it became an unregulated free for all business. It was left to the county governments to regulate, allocate space and tax them etc.

The negative side of this means of transport was their increased involvement in road accidents of the riders. This led to perpetual flooding of head injuries and other orthopaedic victims in the hospitals. Many people also died. '… a ward here it is called Bajaj [mechanized three wheeled taxi] because we get a lot of patients who have had accidents while riding these Bajaj's' (Barasa et al., 2017).

As a recommendation from the authorities special more 'bodaboda wards' had been set aside in almost all counties in Kenya. The main causes of boda boda accidents were: unlicensed and inexperienced riders, overloading, failure to observe traffic rules and corruption among others. The insurance packages were inadequate to cover the riders in case of injuries or death. A motor cycle was generally $2^{1/}2$ times more likely to be involved in an accident than a vehicle.

There were other behind the issues of concern with boda bodas: like cartels manning entry into the business, rivalries between riders and car taxis, increased cases of bike thefts, harassment of members of public and motorists, public, and robbing of passengers. This industry had a lot of potential, but in many ways contributed to strain in health services due to increased mortality and morbidity, prolonged hospital stay, unpaid hospital bills etc.

The Health Act, 2015 (previously Health Bill, 2014) on PART II - RIGHTS AND DUTIES provides under section 14 on Complaints that:

(1) Any person has a right to file a complaint about the manner in which he or she was treated at a health facility and have the complaint investigated appropriately.

(2) The relevant national and county governments shall establish and publish the procedure for the laying of complaints within public and private health care facilities in those areas of the national health system for which they are responsible.

(3)The procedures for laying complaints shall- (a) be displayed by all health facilities in a manner that is visible for any person entering the establishment and the procedure must be communicated to users on a regular basis; and (b) be primarily handled by the head of the relevant facility or any person designated by the facility as responsible for handling user complaints.

(4)Every complainant under subsection (1) has a right to be informed, in writing and within a period of three months from the date the complaint was lodged, of the action taken or decision made regarding the complaint.

(5)Where a health facility or a regulatory body fails to resolve a complaint to the satisfaction of the complainant, the Authority shall take necessary action.

Access frameworks indicated that evaluations by consumers were valid indicators of the ability to obtain care, while this may be the case in for some; it may not always be so as we shall see in the proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) in Chapter Six.

There is need to ensure that health care services and health interventions are premised on people's legitimate needs and expectations even if it means doing clients' exit interviews on a regular basis. According to Martin & Singer (2003), to change communities from being passive participants to active participants in the priority setting process, there is need for them to be empowered to demand for publicity, appeal, relevance and strong leadership in the priority setting process.

It had been found out that when you have a demanding society, governments deliver. Thus, redefining the appeals mechanism and expanding the opportunities for the communities to contribute relevant considerations to each decision and specifying the ground for appeal would help improve the quality of the decision-making process.

Footsteps 93 (see Appendix X) in a small way contributed some way forward in this matter for local residents to appeal to their Governor and Chief Officer of Health. Another useful resource that handles advocacy with such content on writing letters to elected officials is Community Tool Box (CTB).

The Suggestion Box

Complaints and customer grievances cannot be washed or wished away. One of the most useless things in public offices used to be suggestion boxes. They were usually red in colour… nobody took its contents seriously. The keys were usually with people against whom the complaints were made about. Secondly, in this digital age, there were more discreet and effective ways of giving feedback, say through emails and tweets, than leaving your handwriting samples in a box, making them readily available for investigators. ('Lessons on How Not to Fight Criticism', by K. Tanui, *The Standard* Editorial; Pp 12, June 19, 2015).

Social media engagement was limited in official communication terms. Nevertheless it was necessary to impress upon subscribers that some issues ought to be raised internally and not on social media. And in any case one may not expect the answer to be through the social media.

Each organization needed to make its staff and customers understand its model, see how it delivers in terms of communication.

Or Just Ask Them

Community members often expressed strong reservations about the quality of care available to them. They often commented that health facilities lacked competent staff, as well as the necessary equipment, supplies and medicines. Study participants also commented on staffing shortages at local facilities and observed that it could be difficult to locate a skilled attendant at the health facility when one needed information and treatment.

They added that there were usually too few skilled attendants to provide effective services, especially when women presented with complications. (Family Care International, September 2003, Lusweti *et al.,* 2015).

In Section 5.1.2 of Kenya Health Policy Framework: People - centered approach to health and health interventions services aims at satisfying the clients' needs as opposed to disease/program based services. The proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) recognizes these issues and hopes to address some solutions.

The objectives and purposes Reproductive Health Care Bill, 2014 were to-

-provide a framework for the protection and advancement of reproductive and health rights for the women;

-promote women's health and safe motherhood;

-achieve a rapid and substantial reduction in maternal and child mortality rate; and ensure access to quality and comprehensive provision of health care services to women and children.

Under sec 17 of this bill every public hospital whether under the management of a County Government or National Government shall provide free ante-natal care and delivery services. The Bill also sought to deal with the issue of inadequate facilities at county government hospitals, especially in terms of emergency services including but not limited to ambulance services; equipment for intensive care services and gynaecological services as well.

The government aspired to equip at least 2 hospitals per county with modern diagnosis and treatment equipment. Renal dialysis machines had installed in some of them already. There is also a plan to have one hospital per county upgraded into a referral hospital.
It would be a good gesture if the consumables would also be made available on a regular basis. Though a good number of dialysis units had sustained operations, several county hospitals reported a challenge in having to open and re-open the renal units in a matter of months due to supplies and staffing issues.

In conclusion, it is the opinion of this author that concerns the public are like marshals who alert the train driver of possible dangers. This allows the driver to begin the long process of stopping the train. There are instances that the train control systems should come into play and there will be times that human/machine error might prevail. The same way if there are no alerts, disasters which are unavoidable might occur. The health care system requires well thought out plans which respond in a timely manner since health care is never on a standby mode. Some issues we solve on the move.

3.3 Mopping up and Absorbing Health Funds

'Fraud, waste and abuse will cease to be 'a way of life' for the not so few public sector workers'. This was what Former President Mwai Kibaki pledged in his acceptance speech when he became 3rd president of Kenya in December, 2003. But that was not to be, there continued to be what could only be described as grotesque plunder and wastage in the public sector just like before, as we shall see in some examples below.

Public resources at times were geared to 'burning a haystack to look for the needle'. Like spending Ksh 6 million in per diem and fuel for Members of a County Assembly (MCAs) to go for a retreat somewhere in South-coast Kenya to plan for the upcoming investment forum for their county. Who needed the retreat more, was it the MCAs or the investors and stakeholders?

These were areas of health care delivery in this country that only a few book authors would dare want to touch flak, which concern layers of some degrees of fraud. It was like an itch that can't be scratched. It was the bet of this author that every study that would be done to seriously look at fraud, waste and abuse in our public institutions would discover it virtually every time, and not rarely.

At the close or beginning of the financial year it was alleged that among some government line ministries and state corporations there was a rush to conduct several stage managed events, launches, workshops, team buildings, honoraria as a scramble to *mop up* the balances. Some seemingly endless lists of staff names' (and whether accidentally or by design might include a handful of ex- staff names) were invited for the getaway. If not, ever wondered conferences seemed to happen between September and October every year? When allocations come in around August/September every financial year.

Point to ponder

You don't get in unless you can prove you're "one of us." Or if you're evidently not one of us, you should at least know how to look and talk like you're one of us.

Sunny Bindra in Sunny Day. *Sunday Nation* Sept 18th 2016

– *these funds have to be absorbed*. Every other health care institution, university, professional body, association and each of their affiliate chapters, Non-Governmental Organization (NGO's) wanted to have a conference at that time of the year.

Really having conferences was a noble thing but it would be good to spread them out evenly throughout the year if they were to achieve their desired objective. Asking for abstracts at the same time with noticeboards and inboxes sagging with brochures pinned on top of each other just will not do.

It would be interesting to study trends in attendance both at these conferences as well as productivity in the places of work. Some shrewd 'sponsored' workers attended as many, hoping from one into the other. Those in positions flew in and out of the country on a regular basis. It was alleged that in 2015, a certain county sponsored 42 staff to a 3 days' conference locally whose registration fee alone was Kshs 20,000 per attendee, an astronomous amount if you add the each officer was also eligible to a sum of number of night-outs' allowances per diem.

During such a carefree festive season, anything goes. Unimaginable things were known to happen, at some point it was alleged that some fraternities were represented internationally for the same conference by couple(s); either one of them was representing say the obstetrics and the other the general practitioners, midwives and general nurses. Some of the staff in the directories were notorious for such.

What of this? It was alleged the following happened a couple of years back. In an exchange program between Kenya and some Southeast Asian country, some of the candidates represented nurses in a thematic area unrelated to their specialty and practice, just because they occupied some top leadership positions or had the connections.

A disgusted colleague from the concerned thematic area commented '*I think we could say that they represented themselves and their interests not us. All they showed us for all the effort were photographs, no meaningful feedback; the same fellows continued to grab these opportunities now and then. What happens to the rest of us, what about the changes we need? What did the hosts in Vietnam make of us?'*

As simple as that

> Let's approach it this way, do we do single sourcing or go for tender? We do not have much time before 15th of June. What if we looked into some of our prequalified suppliers and ask for quotations (no need to advertise), the tender committee sit and gives it to the lowest bidders (inother words approves and awards).
> Since we are close to the end of the financial year, these funds have to be spent. But we can get a LSO (local supply order) as a commitment. This will be considered as money spent as far finance is concerned. Caveat: This was not to say all such goods were paid for but not supplied but it could as well be. This had come to be referred in some circles as kusema na ku-tender, lipa kama tender tenderprenuer. Coined from Sheng may be to mean that some directive/decision amounted to a complete procurement process. [shared covertly from a procurement committee of one organization]

Hard earned taxpayers' money that has been painstakingly put together for noble causes like quality health of its citizens goes for a song. It was not unusual during such spendthrift seasons for one to hear comments like: *We cannot return this money (balance) back to the treasury*. *Look around for something we can spend it on, it cannot miss*.

One will hear questions like: *how many choirs do we need? Off course we need some scouts to raise the flag and sing the national anthem, I know some. How many*

guests are we expecting? Some notorious organizers instead of cost saving were known to still charge the vote head even where partial or full sponsors for the events were found. (See **Disgraceful elements** below).

Disgraceful elements

It was difficult to imagine that health systems in some developing countries could be this abused. Let us consider the following covert disclosures by a section of health workers:

Oftentimes fellows (those with inside information concerning various vote-heads) have been known to be fight over balances in the budget, looking for what to buy (if it can be called so) to clear it. These balancescould be of various amounts - several hundreds of thousands, perhaps even millions of Shillings.

Wacha tukulakule hii Beyond Zero, Kwanza hii EmOC ujue ni mpaka 2018. Swahili for - let's eat some of these beyond zero money, especially the Emergency Obstetric Care (EMoC) programme, we might still have the chance since it runs up to the year 2018.

Another one commented on the same. *Beyond Zero is for the owners of the land*, *ni ya wenye nchi, si ya diaspora!* To mean that only the locals in terms of staff have the prerogative to run the programme. *Since you came from this or that other county, so you are ineligible for this.*

One was not entiltled to an opinion or proposal as an outsider as there was an ever-present risk of getting blacklisted. This led to a feeling being untrusted and overly scrutinised and overlooked when it came to niceties. All this while their counterparts were inducted into know-hows of 'proposals' writing factoring money for work and money for themselves; the 'legal and straight forward' the how's of how money could go into your pocket. Innocence of trying to use a local dialect in some of these official forums was excused.

Had ethnic consciousness always been a part of Kenya's health care system? Or had it become hardened with devolution? Such exclusivity and tribalism was a backward ideology in modern Kenya but it was entrenched in the systems.

This in some instances had serious negative energy in terms of service delivery, more so quality health care. In January 2014, in a circular from the County Director of Health to all … to require all staff to appear for a head count on 20th and 21st February. Staff took a day away from the facility to participate in the exercise, which included questions about counties of birth and ethnicity. These questions, in a context of wider political contestation and uncertainty, fuelled tensions and concerns among staff that 'outsiders' may *lose their position* (similar sentiments were alluded to in a study by Nyikuri *et al.,* 2015).

'The mtu wetu' (Swahili for - 'one of our own') syndrome will not solve the problems that needed solving in Kenya's health sector. If anything it likely will make it worse.

[32] ww.standardmedia.co.ke/mobile/?...health-workers-strike...kenya See also:

http://www.nation.co.ke/news/Governors-vow-to-go-on-with-staff-hiring/-/1056/2127196/-/1nrswd/-/index.html

Kenya Today, 17th Dec 2013 available at http://www.kenya-today.com/news/betty-njoroge-sickat50-healthcare-workers-relent-strike

This was an alienating feature common to some of these programmes that tended (or were perceived) to discriminate against members of the health care providers perceived to be 'outsiders'. In Kenya these category consisted of those from or "perceived to be' 'they' from *that side* and 'we' of *this side*". Those from this particular county or even some subgroups within the same county. Perhaps to mean an acceptable form of 'xenophobia' had come with the new dispensation of devolution. Moreover, some observers had noted that this far a sizeable amount of county business apparently was akin to that of an employment bureau and consumption rather than income generation. One politician dared to call it '*collateral damages* that came with devolution'.

Usually xenophobia is used for a particular irrational, intense dislike or fear for people from another country. We need to coin our own when referring to a particular irrational, intense dislike or fear people from another county. I call it 'a not belong here'syndrome, unofficially the diaspora an even more despicable term. Such comments would deflate the most resilient of well- meaning souls. It is difficult to imagine how initiatives like Beyond Zero involving some people sacrificing themselves for the good of others, seeking philanthropic others to donate for a noble cause could be plundered, wasted and abused.

This was hypocrisy. A system where people only complain about the corruption they don't benefit from. If you get something from it, it doesn't matter whether it was corruption or stolen money.

Pundits in governance had observed that as they were, government by default lend itself to being plundered. Or rather this was sort of entrenched to create a behaviour that was prone to corruption, almost incentivising misappropriation of state resources among public officers in Kenya. How to reverse this was at all order, but it can be done over time if we have more leaders with a conscience and citizens who were more engaged to solve the countries' problems, in terms of morals, ideals and shape the direction. Nonetheless, Kiambu County Assembly on 17th December, 2017 passed a law requiring that 70% of all Jobs in the county be reserved for the indigenous people of the county. A section of Kenyans condemned the move. Speaking during the launch of *reconciliation for peaceful coexistence and national integration campaign* at Uzima Universty grounds Kisumu, on 10th February 2018, the Most Reverend Martin Kivuva Bishop of Mombasa Catholic Diocese cited the Kiambu csae noting that Kenyans had started being 'foreigners' to one another.

3.3 Bumpy take off

To improve service delivery, in an almost clear rejoinder to the above survey by SDI a call the County Governors caucus also said in no uncertain terms that it would not be business as usual in the devolved public health sector in their respective counties. There was a protracted labour unrest with the health care workers (HCWs) count(r) y-wide[32] downing their tools in much of December 2013 to protest the move to devolve their personnel emolument from the central government to the counties as from January 2014.

By mid-February, 2015 more than 25 counties were yet to release the January 2015 pay for medical staff, this amidst a call for another industrial action, while the many county governments were not able to account for the previous allocations and spending. What the HCWs forgot was that some dynamics of change were inevitable as in the words - come on … *the new move is reaching the hills, the valleys and you…* in the song 'Plantation Boy' by Boney M.

While being interviewed by a national television[33], an official of the nurses' union, Nairobi County Mr Lempike informed viewers that the union had issued a 1st September 2015 strike notice to the County. Among some of the grievances included the usual delayed salaries, enhancement of house allowances and harmonization of pay. Concerning harmonization, he highlighted disparities of non-equal pay for nurses who had the same qualifications, worked in the same station, did the same job. Was there anything that could have been done before this wave displayed itself in the manner that was being witnessed?

With the kind of hostility witnessed on the take-off between HCWs and Governors, coupled with tough economic environment, it seemed that the health care system did not always facilitate the science and art of caring ... Furthermore, some Governors had even proposed to reduce nursing staffing ratios and cut down on some of the allowances that HCWs were hitherto entitled to earn namely; extraneous, risk, non-practice allowance(s). Governors were more interested in efficient utilization of medical staff - number of staff, how they were distributed, how their skills were utilized among other parameters.

Whether to reverse the gains

The following remarks were gleaned from postings KNUN social media wall:

Subscriber one: We do not have a choice about devolution. As usual the medical fraternity failed to know the day of visitation during the constitutional debates and lost a fundamental moment of a lifetime. The few who tried were never on record because they were not so and so from this and that society, association or union for that matter. But at least they did but were never heard. That is a foregone conclusion. As of now, you either adapt or quit. Let us do the best we can to remain sane amidst the changing fortunes of time.

Subscriber two: You cannot now convince a resident of some county (ies) like Xywae, Zee (not real names) that devolution was bad when they could access free emergency services, evacuation and referrals via Emergency Medical Services (EMS) at a click of a number. It had worked for them. Come on!

The fruits, they have been told were just but beginning to ripen; notwithstanding the flowers were blossoming; the branches just sprouted newer ones; the tree had been grafted a pedigree species of deliverables hitherto unknown to the county citizenry. This was one of the 3 counties that doctors for reasons better known to them did not join the 100 plus nationwide strike of 2016/17. (see #**HealthcrisisKE Diaries** below)

With ability to hire and fire handed down to the Governors in the constitution, this could mean many things in terms of access to quality health care for Kenyans (The Kenya Gazette, 2013). Governors commanded huge budgets, second only to the national government control of funds. Chief Officers in the county governments knew that there was a lot of power and money in healthcare. When these two things get mixed generally the politics could be rude and nasty and the HCWs did not like it.

They feared being mishandled by 'rogue' governors. This was what two subscribers posted on Kenya National Union of Nurses (KNUN) wall on 21st March 2014 concerning the new constitutional dispensation (See **To have one of our own** in Chapter 3 and **Whether to reverse the gains** above).

[33]KTN Newsdesk, 20th August 2015, 13.00Hrs Nurses Strike

3.3.0 ♯HealthCrisisKE Diaries

This section was an exerpt from my journaling, first as an interested party and experiential. My current employment sector at higher education had 3 industrial actions happened in 2017 alone. But nothing could be compared to the ravages strikes had on the health sector. This author tagged all of them and prepared some sort of diary: ♯HealthcrisisKE Diaries.

As we ushered in 2017 the health system in Kenya was like a floating bubble, there were more than enough stakeholders with needles to prick it. There was a crisis in the public health system in the country, a spill over from the previous years. Only that this time labour unrests in the country had come full circle.

Doctors, nurses and others went on strike:- at different times; sometimes together or concurrently; while some suspended, others continued; some got a deal while others resumed strike … on and on. The prominence given to either of the happenings in some way indicated the intensity.

More than 5,000 doctors from more than 2,000 public hospitals had managed to sustain a 100 days plus strike which began on 1st December, 2016. Apart from a 300% payrise and additional non-monetary benefits, the CBA ostensibly spelt out demands for equipping and 'restoration of the dilapidated public health facilities', scaling up of the health budget, ensuring continuous training of and hiring of doctors to address a huge shortage of doctors.

Unofficial figures[34] indicated that by the 70th day of the strike over 300 lives had been lost, 20 of these within the first 20 days of the strike. Cancer patients bore the blunt of the stalemate. Patients previously treated at KNH had to seek treatment elsewhere. It was reported[35] that Texas Cancer Center for example received 500 patients up from its usual 200 during that period.

There was need for clarification on the full process of realizing a CBA and more importantly on who should be held responsible at each and every stage. Relying on goodwill from employers will always result to situations like the one below:

During the negotiations, Kenyans had witnessed protracted infighting, turf wars within the health ministry and perceived lack of goodwill from the parties involved. According to the affected unions CBA processes mainly stalled secondary to politically inclined ideologies harboured by Governors.

Deadlock after deadlock, one court extension after another, negotiations were witnessed despite court sanctioned mediation from The Senate, Central Organization of Trade

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34 *Real Victims*, KTN Prime , 1st Feb., 2017; 21Hrs

35 The Standard, Tuesday, 18th April 2017. *The silent victims of the 100 days doctors' strike*

Unions (COTU), Law Society of Kenya (LSK), Kenya National Human Rights Commission (KNHRC), Inter-religious Council of Kenya (IRCK) among others.

With each party slowly exhausting its option, key representatives of each party (the union, the government, council of governors) skipped some meetings, walked out of the talks often. Some mediators gave up as others offered to step in but largely it was the grandstanding and brinkmanship that prevailed.

There was an obvious generation gap with the younger doctors taking an active role in the industrial action. Bloggers and proponents of moral uprightness had a field day posting and reposting what was perceived by the union as 'propaganda'. The private health sector was accused of benefitting from the impasse to make business but that aside the hospitals were far apart and their services were beyond the reach of a majority of Kenyans. On the other hand they were handling more patients than usual, but they could neither stepdown to public facilities, nor offload the credit risk clients, nor refer complicated cases as usual.

There were other angles to this, what might be called a 'catch 22 situation' in more ways than one including **Bringing the CBA upto speed 3 months later** as seen below:

Economically: - Most hospitals generated some of their funds through cost sharing. This in part sustained their wage bill as well as paid suppliers. Undisclosed sources indicated that KNH used to generate Kshs 4 million per day, but it could barely get Kshs200, 000 during the strike. Yet another unnamed one used to generate at least Kshs 25 million per month for the 3 months, it hardly collected Kshs 1 million per month.

Suppliers and informal sectors surrounding health care had suffered great losses. Reports indicated that Webuye Referral Hospital lost Ksh 6m due to unpaid bills as a result of patients leaving due to the resumed nurses' strike from June 2017. As the nurses' strike entered its 4th month it was estimated that Ksh 3b had been lost in terms of revenue for the hospitals.

According to the Institute of Economic Affairs the government of Kenya was grappling with an ever burgeoning public sector wage bill. The unsustainable wage bill was paid to less than 2% of the population (650,000: public servants, state officers and elected leaders). The 2 percent got over 50% of the national budget. This was at the expense of development and economic growth. The president himself alluded to this in a state of the nation address on 15th March, 2017, 'it was bringing the country to its knees'. The regime had experienced numerous pay rise related industrial disputes. Coincidentally this was a day after the doctors' strike was called off.

Delloitte an audit firm had done a report termed 'wind of change' in 2014 which had sought for ways to control the rising public wage bill. The survey had discovered that in some instances remunerative allowances accounted for 70% of the gross pay. In part it recommended that allowances should not exceed 30% of basic salary. It was reported elsewhere that that this was equivalent to each Kenyan paying Ksh540 per month to meet the bill.

Bringing the CBA upto speed 3 months later

On the 80th day, a former Permanent Secretary (PS) Heath before the select parliamentary committee on health and labour was alleged to have signed the Collective Bargaining Agreement (CBA) with the doctors' union Secretary General three months after he he had ceased being the PS three months after he had ceased being the PS Ministry of Public Health & Sanitation or rather 3 months after that ministry had ceased into being.

Alternatively this was *3 months* after health services had been devolved to be under the county governments as stipulated by the constitution 2010. The CBA was not ratified by the Salaries and Remuneration Commission (SRC), was not registered in a court of law and a recognition agreement was not signed with the Council of Governors (CoG).

Surprisingly the former PS called it a template and not the final document. One politician called this blackmail. There was a need to come up with a new CBA that could withstand a legal scrutiny. What became clear was that the document had brought the country this state of affairs. In terms of governance, no disciplinary measures had been taken against this former PS four years down the line. Was he perhaps instructed to 'tidy up' before handing over?

May be this was a *hot* matter they would rather let it cool down. Maybe fight when they were ready some other time *this year-next-year sometimes-never!* But not then. One would only pray that after this doctors' strike the health sector would have to settle now and for all. Hopefully never again would it become necessary to bring it to a standstill. "We would not wish the country to experience this again" KMPPDU secretary general upon calling off the 100 day old strike.

In Bomet, Lamu and Tana River counties the strike apparently did not happen. They continued to receive high numbers of patients from neighbouring counties and beyond. In one of the counties the health care workers had already signed a CBA that had seen their salaries and allowances increased, job group entry point enhanced, drugs and materials provided etc.

The governor and the head of state gave personal donations (Ksh1.5 and 0.5M respectively to be shared among the workers) as a token of appreciation for continuing to render services while others striked. In other words they were pampered. Hopefully this would address the system issues that cut across all counties. What lessons could be learnt? Or was this some window dressing, shoe string approach? Worse still, was it for political mileage? Did the end of the nationwide strike achieve more or less of the same thing? Was it worth the *trouble*?

Much as there were new dynamics and conversations brought about by devolution there was need to 'devolve' the mindset as it were. Unions were unwilling to discuss at county level. They unions insisted that health was a shared function and it was the role of the government to set labour standards and remuneration.

Counties wanted to do matters with a national face, 'the national council of governors (CoG) said this or that'. Each of these proposed outfits were great but they were informal as had not been envisioned in the constitution or the law as it is.

The opposite was also true. The Tharaka Nthi Governor H.E Muthomi expressed his frustration '…we cannot control people who answer to a national union and it's the individual counties paying them'. Let us also consider West Pokot governor's wish list: why not devolve the unions to the counties? Why? No matter how well individual counties felt they had performed in the health sector, the national union sort of dragged their staff out of work by calling for a nationwide strike. In effect the governors felt helpless on matters to do with labour disputes. SRC's advisory role was mandatory and binding in all matters remuneration of public officers though it was the government's role to look through its fiscal policy in relation to

those recommendations and then implement what seems fit. SRC decisively endeavoured to cap allowances and issued circulars to that effect. It had also carried out a job evaluation of all civil servants (though some sectors declined to be evaluated) and made recommendations of new salary scales. Every union (in its wisdom) wanted to beat that date by clearing any pending issues. This was expected to take effect sometimes in July 2017.

Earnest & Young and *PriceWaterHouse Coopers* contracted by SRC to do the JE using Paterson model for job evaluation the job holder described job and explained the duties and responsibilities on which time was spent. In a systematic way determined the value/worth of a job in relation to the other jobs in the organization. Somehow the tool assessed the performance or appropriateness of the current incumbent for the role using the principle of 'fair pay for fair play'.

The outcome would help the human resource department or an authority like Salaries & Remuneration Commission (SRC) to develop a detailed, updated job description of the role and pay structure. This way it would be possible to evaluate the job in future. Generally Paterson grading model banded decision making. Downloadable PDFPM 6 form. For instance, it rated administrative staff higher than teaching staff in the universities, a highly contentious point that provided an axe to glide to the unions.

Without belabouring the point, increasing wages without decisively dealing with the rising cost of living and the unregulated spending of public resource was like shooting on a moving target. If that indeed was the position by law, it was then the national government's role to negotiate CBA's, and then the county governments would have to comply with the recommendations. As such it was necessary to get an interpretation of the constitution on several matters labour.

It was notable that around the same time of the doctors' strike, public university lecturers called off the 54-day strike after the government awarded them a 17.5-percent salary increase following intensive negotiations. Kenyan university lecturers on January 19th 2017 had downed tools citing the government's failure to honor an agreement on salary increase and better working conditions.

Their 54-days strike paralyzed learning in 33 public universities while putting cutting-edge research programs in jeopardy. Health sciences disciplines students and interns could not access the needed experiences for the 100 plus days and they were not in class either. It appeared that the boycotts were demoralising and radicalizing traineees too as some issued solidarity statements through their students' associations..

However, dons through the university academic staff union (UASU) and Kenya university staff union (KUSU) resumed the strike from 1st July 2017 unless the government honoured the Ksh 10b deal they had reached in March of the same year (the government instead released 48% of the figure promising to pay the rest at a later date).

The dons were not amused and insisted on getting the full amount, meanwhile the strike continued. The strike was called off on day 18th with a written commitment undertaking to release the remaining Ksh 5.2b. This was not honoured and therefore on 1st November 2017 and again February 2018 the dons resumed the strike. This was their umpteenth strike. As a result estimated 4 year programs would be taking on average 6 years to complete. This author happened to be a faculty member during that period.

On the same note, nurses and clinical officers on the other hand threatened to reenter the strike they had called off a month or so earlier. In Nyeri County, the 1000 nurses' workforce went on strike in May 2017 citing lack of promotions and non-recruitment of more nurses since 2013, yet more than 400 nurses had since left the service. They alleged that a ratio of one nurse to 40 patients was putting too much pressure on them. On 30th

June nurses from Moi Teaching & Referral Hospital downed their tools citing failure of the hospital management to implement the CBA that had been negotiated 4 years earlier.

Around the same time KNUN governing council issued that the 25,000 unionised nurses resumed from June 6th 2017 the nationwide strike they had suspended 5 months earlier unless the Council of Governors signed, registered in court a negotiated CBA, and resumption of the Nurses' Allowance which had only been paid once with the January 2017 salary. However, in one level 5 hospital the strike was more of a continuation since its nurses hardly resumed from the December 2016 one.

This was a long-drawn-out work boycott by all standards, by the time it went into the 5th month it was apparent that it might not be ending any time soon given the continued antagonistic positions by the parties. As a result of the prolonged industrial action, every other department in that hospital was in effect immobilized.

Every other union seemed to make good their threat and the strikes took place. Preemptive measures apparently did not to work each time. Seemingly, there was an apparent lack of goodwill to resolve the crisis or may be there were no solutions after all. Parties would snub appointments and meetings that had been agreed on just the previous day.

What resulted was a crisis meeting after crisis meeting. It was during a press conference called to deliberate on the ongoing nurses' strike (Day 2 of the resumed strike) that at one point, Kisii County Governor Ongwae speaking on behalf of the Council of Governors (CoG) asked that *governors be given a break*. A break from what? Looking at it from another perspective, it seemed they were looking at nurses' grievances as something perky, not deserving of a break from their busy re-election bid campaign trail.

On the other hand SRC argued that a valid CBA must be backed by a letter of no objection from them, as each commitment must be in tandem with the ability to pay. This was not always the case. Parties had negotiated CBA's without considering where the money would come from in the short and long term. Issues kept on coming up that had not been considered in the earlier negotiations.

Some negotiators were not sincere in that some of the things they had agreed on were not implementable. Some parties had not brought on board the SRC on time, while at the same time they accused it of misinterpreting its role and pronouncing itself on matters beyond its core mandate.

The disputed figures per nurse per month were going to be: *Ksh 25,400 Nurses Allowance; Ksh 15,400 Health Risk Allowance; Ksh 5,000 Extraneous Allowance; 5,000 Responsibility Allowance and, Ksh 50,000 Uniform Allowance annually*. Parties released conflicting information e.g. the CoG was talking of Ksh 40.3b in the four years if the CBA were to be implemented as it was, nurses talked of Ksh 7.5b annually. Why the disparity? Let's look at the following example.

But then was it money that was essentially lacking. Reports from National Treasury as on 14th August 2017 about Ksh 33.3b of county idle funds (unspent) was at Central Bank of Kenya (CBK). This was some 4.7% of Ksh 698.8b of cumulative transfers to the counties as at July 8th 2016.

The governors generally blamed the Integrated Financial Management Information System (IFMIS) for the slow absorption of funds. This was despite constant disruption of service delivery especially in the health sector. If indeed this was so, unspent funds could be due to undelivered service or mismanagement.

It was apparent that SRC had not been part of the negotiated deal all along. Nevertheless, on 9th June it gave guidance to CoG (and especially) the nurses' union to reconsider their position. All this while the Acting Secretary General (SG) swore never to sit in a meeting to renegotiate the CBA. This grandstanding went on, in the over 60 days not more than 2 substantive meetings between the parties had taken place.

When a new CBA was likely to happen? Though SG pointed out that there was light at the end of the tunnel now and again (possibly referring to the new CBA) he equally stated, 'the strike was now reloaded, nothing has changed until we say so!'

With all due respect let us contrast the above chest thumping approach with what CM posting on social media on 5th October 2017, '*…the SG... was astitute, cool and above all, pragmatic. He ably articulated members' grievances without issuing threats, ultimatums and was not frothing in the mouth and gesticulating wildly in the presence of his employers.* This particular RTWF was signed on day 18 of their strike (by then nurses doing 122nd of their strike).

The dilemma on how to resolve the perpetual industrial actions was real in a country where citizens did not want to be taxed more, with rising inflation as reflected by rising prices of consumer goods (by mid-2017, 2 Kg Unga or maize flour Kenyans' staple food was retailing at Ksh 160 and a Kg of Sugar at Ksh 200), prolonged dry weather and famine. May be the battle seemed in many ways about food security after all, someone felt.

Seemingly, some politicians wanted to capitalize on the situation and make a kill. Unfortunately in the process, real patients also died for lack of care. By day 8 of the resumed nurses' strike, ten deaths had been reported and there was fear that the strike was getting out of hand and likely to become a runaway situation like the doctors' strike that had just ended some 2 months earlier.

This was compounded by the upcoming closely contested general election with some ifs about the repeat presidential election of 26th October 2017. It seemed we had to hold the election somehow.

According to an SRC blog by Sarah Serem (chairperson SRC) the current industrial unrest could hurt Kenya's investment plan. It could ruin the country's reputation as an investment destination.

SRC was established under *Article: 230* of Kenya's Constitution with the objective of bringing sanity and order in the management of the burgeoning public wage. The wage bill in 2016/17 fiscal year was Ksh 627 billion (about 52% of the total revenue of Ksh1.3 Trillion) for the 650,000 public workers making it the government's largest expenditure. In effect making us a consuming rather than a productive economy (short of going The Greece way) where less than 1% of the population consuming 52% of the revenue. SRC targeted to progressively reduce this to 35%.

The emotional component: - Salary is an emotive issue which can be quite volatile. It is difficult to ensure a health industrial relationship as prescribed by the law. Strikes whenever they happened one has be ready for the emotional journey. When things are down as they could get during an industrial action collegial social support was critical. It gave strength to keep walking, converge for purpose of demonstrating and keep the focus.

It was emotionally draining when parties waited to act when pushed by strikes. Unfortunately it seemed strikes had evolved into a mode of communication. It was bad enough to negotiate a give and take with perceived insincere partners during a strike. When one was under pressure it was possible to make an irrational decision for instance:

On the 71st day the 7 officials of Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPPDU) started a 30-days jail sentence (previously suspended for a month) for contempt of court for failing to call off the strike as required by the industrial court.

The Council of Governors had filed the case, the industrial court declared the strike illegal and ordered the officials to call it off failure to which they would face a custodial sentence. The bone of contention being the failure of the government to honor a negotiated 2013 Collective Bargaining Agreement (CBA) [36]

The private practitioners in solidarity with the jailed union officials christened 'CBA 7' withdrew their services for 48 hours essentially paralyzing the health sector countrywide. They were released 48 hours later after a successful appeal. In several ways, jailing their leaders infuriated the doctors, cemented their resolve to soldier on and could have played a role in prolonging the strike.

Much as it was apparent that a lot of people would have liked to see the problem solved amicably many were experiencing emotional fatigue. No less than the secretary general of KMPPDU admitted to this in a letter to colleagues entitled *we shall heal* on March 8, 2017 wrote: '...public have grown weary and stretched by unending stalemate…' With accusation and counter accusation, and perhaps the public being advised by misinformation.

Parties were reading blackmail, frustration, anger among others. The cabinet secretary Ministry of health noted 'It is regrettable that it took so long and we cannot begin to fathom the extent of the pain that Kenyans have suffered. Those 100 days will remain black days in the history of medicine in this country and that is not a record we want to keep'.

Betrayal was a common perception. The doctors clearly admitted that their work was hampered by the nurses' strike and vice versa. It was no great time for nurses on contract, interns, casuals and those in management who were deemed to be 'somehow' working while the rest were on strike.

The Chairman of KNUN was opposed to the resumption of the nurses' strike citing that the negotiations were progressing well and expected to be fruitful. Suspicions that union officials could have been compromised were common in such developments. The major

[36] www.kmpdu.org/documents

fallout among union officials played out live on national television on day 12 of the nurses' strike as each faction wanted to address the press conference at Nairobi's Railway Club.

The unfortunate incident of 'battle of egos' was not just embarrassing for the profession but also caused panic among the nurses. This was also apparent going by the various factions pulling in different directions, each with its own social media platform, lots of mudslinging and vitriol posted against each other.

In some counties it was reported that nurses had reported back to work by the second week. On day 23 some striking nurses were teargased by riot police outside MTRH Eldoret while picketing to eject some of their colleagues who were on duty. It was reported that the hospital had hired about 51 nurses during the crisis.

Nothing could be more disheartening than being ignored over such a weighty matter as an industrial action. While the political class continued with the 2017 election campaign, the striking nurses continued to hold demonstrations all over the country but it no longer made headlines. The matter was being treated with remarkable nonchalance. A news anchor somehow captured this contradiction 'mgomo wa wauguzi unaendelea kwa siku ya 38, ukiendelea ukisahaulika' in colloquial Swahili - *even as the nurses' strike entered its 38th day, it was apparent that it had slowly been downgraded into a none issue.*

Day 38th also happened to be 28 days to the general election of August 8th. While everyone saw that it would not be long before the strike was resolved little did anyone imagine would drag past the general election day, but it did, One Kenyan nurse observed: 'Nursing was becoming invisible in Kenya. The government seemingly did not prioritize nursing as a profession in our country. The political class were not willing to articulate the nurses' voice and experiences in revealing the health care systems' current predicaments and possibilities. Sort of they felt embarrassed by the strike'.
Seemingly the public had become increasingly disenchanted with strikes. Various interested parties observed that after the general election there was need to face the reality, need for a strategic retreat, may be call off the strike and re-strategize. But that did not happen.

The political class kept on the campaign tempo as if the strike had become a non-issue. The strike was relegated to backstage because of political campaigns which had given it a blackout. It had become apparent that election campaigns made state officials lose focus on issues affecting Kenyans, until after elections. Worse still, most politicians only mentioned the ongoing nurse's strike in passing.

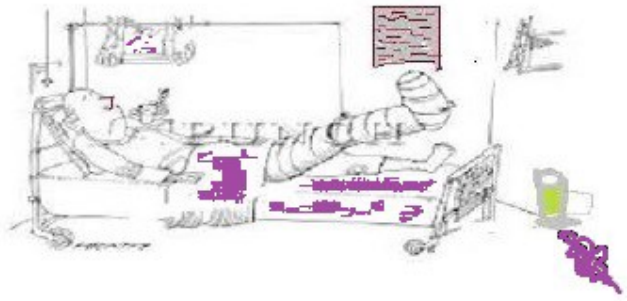
May be the timing was not that good after all as some came to realize but then the acting SG had to somehow come to terms with the circumstances, 'governors focused on the voter not us, blame them for the strike not us', he admitted to one of the dailies and as released to nursesarena.com on 6th August 2017. 'They turned up at the negotiating table without a meaningful agenda', he added. But then CoG chair of Health Committee put it as it was when he said, 'we had other engagements that we needed to attend to'. If indeed this was so, was KNUN expecting too much on their part to surmount the intricacies of negotiating with transitioning parties?

The authorities could not afford to be at war with their own professionals. They needed to raise the confidence health care workers had in their work. More critical for the professionals was what became of thousands of Kenyans in dire need of healthcare?

It had been observed that the strikes affected the health seeking behaviours and patterns of Kenyans. For one, immediately the strike starts the numbers of patients drop stat! Expectant women stop coming for deliveries, perhaps opting for traditional birth attendants (TBAs). Emergency rooms are deserted 'one wonders where the casualties were taken'. Lots of non-adherence issues arise for patients on chronic medications including ARVs, TB among others.

Seeing 'sick' patients being forced to vacate hospitals was an extreme no health care provider wished to go, many too poor to afford to go elsewhere. Some of them were not even able to clear the public hospital bills they had accumulated so far.

Patients on skeletal traction were especially vulnerable, they were forsaken, and a number of them were reported to have remained in the deserted wards throughout the strike. For a good number of patients though, home was no good and they would rather have stayed in the hospital.



Pic: Patient on skeletal traction (Courtesy of clip developer)

The role of caretaking was left in the hands of ill prepared significant others (Chapter 14 of this book is dedicated to the role of lay care providers). The emptiness characterizing hospitals during strikes was a ghostly site. Abandoned equipment and supplies would often get vandalized or stolen in several such facilities. It was a common observation that many would not be returning to a better place.

Mental health units were worst hit by the industrial action with media reports showing incidences. The few remaining ones still operating being overloaded. The facility at MTRH in Eldoret, which serves about 80 patients - double the capacity - was overwhelmed. It was reported that some patients relapsed on failing to get medication and treatment at county hospitals.

For some unfortunate union members just like the doctor's 'CBA 7', the nurses' strike turned personal. Services at Port Reitz - the second largest mental health institution in Kenya after Mathari Mental Hospital in Nairobi - ground to a halt or doing with minimal care and treatment. Three nurses from Mathari Mental National Hospital were arraigned in court allegedly for 'recklessly and negligently allowing mentally sick patients to escape by unlocking the gate'.

Politically: - Whereas the political class in Kenya paid themselves outrageous amounts, and raided the public pulse often, health care workers were required to make concessions on their demands. For example members of parliament (MPs) forced through a raft of allowances against the capped SRC recommendations. They somehow managed to manipulate SRC against capping the maximum allowance they could earn.

Two days after the doctors' strike was over MPs allocated themselves an additional Ksh 6.5 billion send-off package as a compensation for the reduced term (from 5 to 4 and half years). They wanted this factored in the 2017/18 financial year budget which was to be unveiled in 2 weeks' time (read on 30th March, 2017, was read earlier than usual due to the general election). They, in one voice firmly pushed for an award of a severance pay to cover the eight-month reduction of the usual five - year (*read* severance pay for work not done).

Each MP in Kenya earned on average Ksh 1million and enjoyed tax exempt on their earnings. The debate continues as to whether the elected leaders should pay taxes on their earnings. Their perks were by and large 'untouchable' going by their displeasure over SRC's recommendations to reduce the earnings of the (incoming) 12th parliament among other state officers. These were big demotivators towards expecting others' willingness make concessions.

Lawyers representing the doctors apparently needed *political mileage* out of the cases since this was an election year! One of the said lawyers had declared interest in the presidency of the country. Getting a win-win solution was difficult without soberness and rational thinking. For both sides, it was necessary to abandon the hard stance and go back to the drawing board for the way out. It became obvious with time that no intermediary could ably solve this, perhaps *unless divinely*.

Being an election year: the opposition blamed the government, the government blamed the doctors and said the opposition was politicising the crisis. Union official said: "For us, the strike is still on until we get what we wanted ... this government has shown is it lacks empathy for poor people". The government on the other hand accused doctors of "using the lives of Kenyans as a bargaining chip".

One of the opposition pointmen even proposed health services even though it was a shared function be partially removed from the counties but not totally reverted to the national government. Further, health system must be reorganised and workers hired and managed by the central body (national health commission), similar to Teachers Service Commission. He said this as he addressed thousands of energised doctors and medical soon after the release of the KMPDU officials.

On the 93rd day the Inter-Religious Council of Kenya reported to the appellate court that on the basis of concessions both sides had agreed on 95% of the issues. But then, the government seemed to be willing to give no more than a 50 percent payrise offer equivalent Ksh14.5billion (or else take or leave it).

Emerging from the 4th annual devolution conference mini-summit was some seeminglyunpalatable news. The executive together with the council of governors issued a joint statement which seemingly watered down the said 'gains' as it were by withdrawing the enhanced Ksh 600m incentive in terms of additional backdated risk allowances effective from January 2017.

Everyone was concerned about what was going on on the health sector and their stake. For intance, The 2nd HeSMA Leadership Congress, Kisumu in May 2018 discussed on proposed Scheme of Service for health leaders, credentialing guidelines, proposed health and leadership guidelines.

Among others the press statement spelt out the doctors to: resume work immediately, recall of the registrar doctors on study leave back to respective stations, doctor interns to resume their clinical attachment forthwith, reconsider review of registration and certification of doctors by Kenya Medical Practitioners and Dentists Board (KMPDB) and revert the role to the Ministry of Health. Consequently there was a new tune, the mediator and the union were pleading - 'come let us reason together … this one last time'.

Looking at it from another angle, it seemed some employers somewhere had been disappointed all along. Consider the following: According to one such governor [37] the county had 35 doctors in 2013 but only 17 were available to render services, the rest were on study leave, 'some study leaves apparently extended beyond the Governors' term in office, yet they were on the county's payroll. These were some of the anomalies we have to rectify'.

In yet another occasion during the doctors strike, no less than the country's chief executive complained (*paraphrased*) '… we (*ad-lib* are offering to) pay them so much but they work for … hours a day in public hospital and then run to their private practice,… this is blackmail and we are not going to accept!' However, the president's intervention (goodwill) had been very consequential on the outcomes of the strike. Doctors had many things to thank him for the interference.

But when it later came to the nurses' strike (in its 50 plus days on 29th July 2017, it was a matter for the CoG's since the national government had already paid out their staff (may be he forgot MTRH nurses were under the national government were also on strike). The KNH nurses threatened to join their colleagues in solidarity.

Not withstanding KNH was a 'sickly' hospital and this was variously reported in the media [38] a sad state of affairs on 3rd August 2017. Most striking it was - *a dozen or so mothers sitting on a bench alleged waiting for emergency C/s for over 24 hours in a filthy labour ward*. The country's health systems were getting more unpredictable, the processes were becoming unclear, and the outcome equally so. Considering for example the gains made by the free maternity care, the Beyond Zero, Managed Equipment Services Project etc. were being eroded further with each day of the strike.

Out of about 260 doctors in KNH 60 of them had participated in the strike, the hospital went ahead and fired 12 of them in the wake of the stalemate. It took the hospital a week to have the return to work signed after the strike had been called off.

The counties put the striking doctors on notice preferring disciplinary action to those who would not have resumed duties by certain date. The Ministry of Health and the counties

[37] Focus on Busia County, K24, 6th Feb., 2017; 08.00Hrs; interview with H.E. Sospeter Ojamong

[38] Citizen TV, Thursday 3rd August 2017, 21Hrs, *Sickly KNH.*

however chose the longer bureaucratic disciplinary guidelines. The council of governors (CoG) said as much that they were gearing to start engaging expatriate doctors from Tanzania and Cuba among others 'who were cheaper'. This was assuming issues like culture shock, prejudice and legal hurdles they would have to face. In the aftermath it was reported that Kenya had started importing Tanzanian doctors with the first batch of 500 expected later on.

However, an injunction was filed in court barring them on the ground that the law was clear that for a foreigner to be recruited then there could not be found a local with the similar qualification. There were about 1400 doctors who had cleared medical school, who would be joining the workforce the later in the year. Apart from this there were a number of unemployed doctors in the country. This was not to say that we were anywhere close to getting the ideal number of doctors in the country. KNH for example had 264 doctors but its ideal was about 2000.



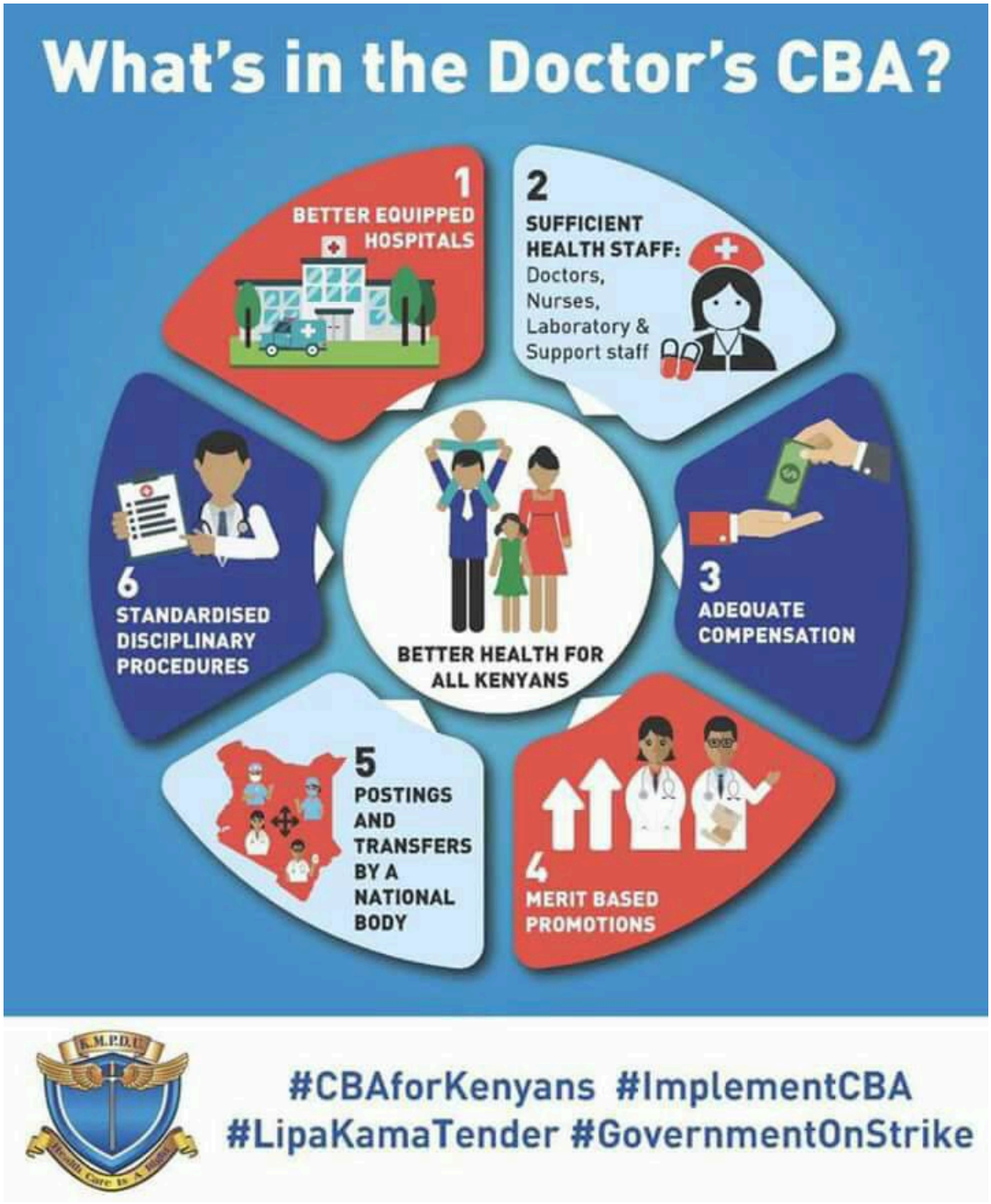
Picture: Kenyatta National Hospital main entrance and tower block

(Photo courtesy of the BBC News photographer)

Concerning the nurses' strike that coincided with the active election campaign (started on June 5th 2017 which was 65 days to the general election date of August 8th). The onus was on the government to ensure the nurses' strike did not go past the election date; unfortunately this became a reality with every passing day, badly bruising the nurses' ego. Moments of crisis were moments of opportunity also.

Crisis turned into circus and the way out for everyone was to blame politics for everything including the strike. The opposition used it as a pointer to the sitting government failure to offer basic health care to its citizens by addressing workers' issues.

After the election as expected there would be the settling downtime especially for new members of the council of governors and possibly a whole lineup of a new government. In other words a new set of players. Then, there was the Supreme Court order for a re-run of the presidential elections in 60 days (and a foreseeable possible postponement of the same).



Caption used with permission, KMPDU

Experts including SRC agreed that disparate pay (and not necessarily inadequate pay) was responsible for most industrial disputes in the country. When one health profession was (over-)pampered at the expense of others it would come as no wonder that it fuels conflicts and further labour unrest. Some counties apparently did their bit.

In county Zendi, a medical officer just after internship was recruited at job group 'P' as opposed to 'L' in 2 grades above majority of counties. A nurse on temporary contract was appointed at Ksh 32,000 which was like double what other counties paid. Unfortunately contracts were renewed on yearly basis. Some cadres it was done half yearly. This category of staff continued to offer services during the national health workers strikes of 2017/17.

While the rest of the country had health crisis no strike was reported in Zendi County. While for some of the counties the strikes threw their systems into a tail spin where facilities were literally closed. How was it that other medical cadres could not continue without those on strike? Time to learn from Zendi County - what systems were in place? How sustainable were they? Would the same survive the goodwill of the incoming governor (as became the case)?

3.3.0.1 Over and Out?

The doctors union called off its 100-day strike after reaching a deal with the national and county governments. "The signing of the return to work formula (RTWF) ends all the remaining contentious issues between the parties" in part read the statement Inter-religious Council on the 100th day. RTWF removed all the pending disciplinary measures and victimization on the doctors.

On the other hand the secretary general KMPPDU said "We are happy that the doctors union have finally put an end the strike. While the strike is over, the dispute may not be…" Among others a collective bargaining agreement which was signed in 2013 would be renegotiated within following 60 days while doctor's services resumed.

There was need to bank on the remaining goodwill to close in on the pending issues. The CBA would cover doctor salaries, welfare programs but improved health facilities. If only the public could then see that the fight was about them (a stable health sector).

As if to point towards what was expected, counties were not willing to pay for the months the doctors were on strike 'not working' and there was renewed call into action some weeks after. Isolated softer demonstrations and go slows were not unusual across the country since several counties had *struck off* the doctors from their payroll for March 2017. No other than the president himself intervened directing that they be paid. Counties insisted they would *not pay for work not done* or else did not have the money all together, seemingly the funds tranche had been spent?

Ironically, some counties asked the government to provide the money for January to March, 2017 to enable them pay the doctors. Where had the money gone? Being an election year county bosses were engrossed in election campaigns to pay attention and resolve the matter once and for all.

By 1st May 2017 (Labour day), KMPDU issued a warning paydoctorstoavertstrike.

It was indeed, disappointing to let the matter drift towards the resumption of the total shutdown that was experienced in public hospitals countrywide. By the middle of that month the CS Ministry of Health indicated that Ksh1.5b and 1.6b had been released to the counties for doctors and other health care staffs respectively even though most counties said they had not received the said disbursements. Along the ongoing twists and turns, two doctors on 19th May 2017 filed a case in the industrial court to compel the Ministry of Health and Council of Governors to pay the doctors.

Unfortunately quite a number of doctors said they have had enough of it. Sources from the union indicated that about 10 % of the total 3900 doctors in the county had left in the immediate follow up of the industrial action.

Undisclosed sources had indicated that a handful of them were waiting on the wings; to take the factored accumulated arrears in one hand and resign from public sector with the other, 'shake it proper'. If this would happen, what a *slap in the face* if they made good such a threat. Only time would tell.

It was not surprising then that the Secretary General KNUN at some point hinted what appeared to be an ultimate way out, 'layoff everyone, pay pension, readvertize, whoever wants to work for counties can go ahead and apply'[39]. May be may be not, but then this suggestion might create a critical mass of county government employees who might be easier to manage.

This author would not be surprised that some governor somewhere wished *if only there were funds enough to pay off the damn terminal dues; we could do away with this nagging lot and start afresh with some of our own*.

Seemingly there was some disproportionate negative energy among the striking unionisable comrades in relation to the gains accrued. To this extent some pundits felt that after 100 days the doctors finally settled for (more or less) what the government had offered them on Day 2 of the strike. It would not be surprising if and when the nurses follow suit and took the risk allowance and uniform allowances and RTWF they had been offered on 5th June (or rather Day 1 of the resumed strike). But then it was not all about the money, it was about a better health system.

The medics needed to come to terms with a humbling reality, the fact that ttheir *new* bosses were the governors, county chief officers, members of county assemblies and a myriad of others including policies from the ministry of health. That is how it was meant to be in the first place with devolution.

The ghost was not being put to rest any time soon. In the words of the KMPDU secretary general on interview[40], 'The strike is off, no one is talking about patients suffering, but each day we are seeing patients suffering'. Or rather, 'we are not yet there, we may not have got all we set out to do, but we are well on our journey there'. On 27th May while issuing a further 'final' two weeks within which to have the CBA signed the

[39]Daily Nation, *Healthy Nation* 15th August 2017 by Vera Okeyo; [40]*KTN Friday briefings*, 7th April 2017, 21:00Hrs; B. Kyalo Interview with Dr Ouma Oluga, as a guest anchor

Secretary General KMPPDU said, 'In the period we have been negotiating with 9 to 11 different teams over the same ISSUE. The pace has been painfully slow'.

The doctors' CBA was eventually signed on 30th June 2017 with the Ministry of Health and salaries Review Commission (SRC). Finally with Council of Governors (CoG) on 6th July 2017. Eventually it was filed in a court of law on 18th September 2017.

It indeed promised good tidings for the union members going by the contents available on: www.docdroid.net. The officials in a press conference indicated that this was a milestone not just for the members but for the country's health system. But then the journey had just began; that of implementation and consultations etc. *[P.S It was not all rosy for them or anyone for that matter, by end of March 2018 Treasury was reported to have backed off on the Ksh 11b deal with the doctors likely to ignite another season of labour unrest]*

Something else accrued from the experience: mediation & negotiation skills, concerning which they felt confident that they could make a difference if called upon. On 18th September KMPDU had their CBA finally filed in court of law, this was 287 days after it was signed, which was 200 days since the 100 days strike began.

The KMPDU SG extended to help out any parties that were having challenges in terms of negotiating, signing and filing of a CBA. This was certainly a welcome gesture since KMPDU apparently was leading the way in this case. Hopefully other unions would take the cue. May be referring to the nurses' strike which by then had entered its 106th day then.

But then, with all due respect it would not be fair to use the doctor's strike as a bench mark to resolving the nurses' strike or any other for that matter due to the unique requirements of each. The timings were different with nurses' strike standling over a transition between 2 governments. Moreover the two were not being handled with equal importance.

A.M. on *KNUN Official Forum* Facebook wall posted on 15th August 2017 while responding to J.M's *Law of diminishing* returns '… even if doctors took 100 days, at least they were talking, are we even covered by media comprehensively? No'. On the other hand by the time the nurses' strike clocked the 'revered 100th day' (as one faction insinuated) on 12th September that year, it was apparent to a good number of them that there was not much to show for it.

Politics of the day had overshadowed the nurses' strike. There so much to say concerning the state of the nation and less on the nation's state of health. There were hardly more than 2 mentions per week concerning the strike from the 2nd week of July upto late August 2017. Again, reporters were looking for content and in the words of one of those interviewed '…there was not much to report' #BehindTheHeadlines, a half hour feature based on the nurses' strike on 23rd September on *KTN News*. On the other hand the doctors' strike happened at a time when it was possible to have it in the headlines on a day-to-day basis.

Why the hurry when you can wait yet another day? On 81st day of the nurses' strike the Kenya's president elect himself while launching a new cancer treatment plant (cancer therapy and digital radiotherapy simulator) at KNH lauded the hospital's nurses for continuing to offer services even though their counterparts in the public service were on

strike. Way forward – 'let's give these governors some few weeks to settle then we will look into their (nurses') issues, meanwhile resume work.

KNUN did not call off the strike there and then, but by and large many nurses had resumed duty. Indeed on 86th day, the newly elected Nakuru governor instituted a task force to report on the nurses' industrial issues in 30 days. Nyandarua, Tharaka Nthi counties also saw the need to give dialogue a chance. Seemingly the stick (threats, intimidation) had failed miserably and it was time to try the carrot (dialogue).

But then either side should be given the benefit of doubt. The striking staff continued receiving their full pay despite being out of work for 100 days or so. Only one or two counties had stopped paying and even then they still paid some in what had come to be referred to as 'a divide and rule basis', some form of intimidation.

One health services manager put it squarely '…as long as salary has not been stopped some do not see why the strike should end'. Another one added, 'I know three of them who were seriously into business 'now earning double''.

On 31st August 2017 (88th day of nurses' strike), the Council of Governors consisting of about 30 present out of 47, together with representatives from the Public Service Board and SRC among others, having received the report of the previous 3-days negotiations with KNUN officials including allegations that that nurses had reneged on call allowance among other demands.

The CoG declared the strike illegal, that the CBA could not be implemented in the form it was. They went ahead to issue a 7-day ultimatum for nurses on strike to report to work by 8th September 2017 or face the sack. Upon expiry of these notice, some CoGs went ahead to advertise for vacancies in terms of 1-year renewable contracts for those who would be replacing the ones on strike.

The CS health went ahead on 120th day to direct that the nurses be sacked, and that the government was going to take administrative and legal implication on the individual nurses who will not resume duty as ordered by the industrial court. He said this during the opening of Annual Catholic Health Conference. He ruled out any further talks about the CBA until the nurses were back to work.

Things were complicated by Supreme Court of Kenya ruling on 1st September nullifying the presidential election, ordering a fresh one in 60 days. The same day the industrial court declared the nurses' strike illegal and ordered the KNUN national governing council to call it off in 7 days.

This implied that the nurses' strike was unprotected by law. Failure to which they would be jailed for contempt of court. The response from the Union was 'strike reloaded, reenergized'. It had been demonstrated in many an industrial action that a CBA was impossible to achieve without ceasefire and good will on both sides. Would it follow the road of the doctors' 'CBA 7'?

Would the national nurses' strike straddle 2 general elections? Was another 97 days too long to wait?

Or longer had we gone to January 18th as some of the sentiments of 'No election26th October until and unless the *minimum irreducible minimums* were met' on the presidential elections front were realized.

Around 5th September clinical officers- Kenya Union of Clinical officers (KUCO) issued strike notice. KUCO made good their threat and started the strike on 15th September. Their borne of contention this time: SRC (report yet to be made public) job evaluation had demeaned them from professional to semiskilled, a grade discretional Band B'3'.

Laboratory scientific officers, pharmaceutical technologists and radiographers issued a notice and some held demonstrations, the main issue - rejecting 'insulting grading structures by SRC' of their profession. Sources indicated that radiographers were also on the wings raring to join in. Various quarters suspected that these banding was meant to give the CoG a reason not to honour a CBA with 'semiskilled' workers after all.

According to Dr. Abdi Mohamed, chair Association of Private hospitals (*The Nairobian* October 20th 2017 pg. 15), the health sector took a nosedive when the health function was devolved … Devolving services soon eroded the gains made on public healthcare dogged by doctors' and nurses' strikes.

On 2nd November 2017, day 151st of the nurses' strike a deal had been negotiated that would see the strike that started on 5th June 2017 being called off. The return to work formula included nurses on strike being required to report back to work in 48 hours; there would be no victimization for taking part in the strike, withdrawal of all show cause letters for taking part in the strike.



Photo above showing agitated members of the nurses' union in the recent strike

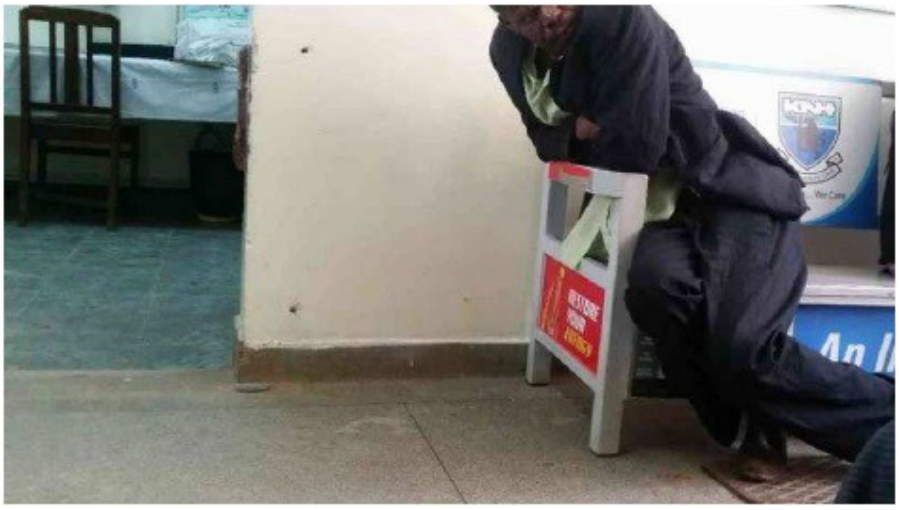
[Photo Courtesy of Kenyannews.co.ke]

The CBA would be signed within 30 days. Grading issues would be sorted out pending a court case. Further, payments would be staggered in 3 phases for Nursing Allowance of Ksh10, 000 per month, Uniform Allowance of 15,000 in the next financial year.

The resumption of work was not without its share of challenges: some counties (e.g. Murang'a) had already ' replaced' the striking nurses with others. Garissa County was mostly serviced by non – indigenous staff and there would be logistical challenges for them to be expected to resume duty immediately. Most of the nurses were not on pay and the next pay was expected by end of November 2017. A section of them wondered, 'how do you report to work with no money?'

Apparently some counties also had their own pending domestic grievances with their nurses. A case in point was TransNzoia County branch union's officials warned that …turudi halafu tupeane notice. Swahili for *even though we are to resume but we will be issuing our notice (? another industrial dispute) soon*.

The conclusion of the matter was: The need for better affordable healthcare remains and that the health workers' strikes in the tail end of 2016 and three quarters of 2017 were seen by proponents as a means to advance a better healthcare system for the country.



Picture: An obviously distressed patient waiting outside a deserted consultation room during the height of industrial action by doctors. [Courtesy of the photographer]

The post script

When all is said and done concerning Kenya's healthcare crisis: My two cents - there is more to consider than the need to call for an industrial action most critical being –Timing! The social economic political circumstances played out louder than the ongoing industrial unrest.

On 10th July SRC released new guidelines for allowances, job grading and salary structures, remunerations of state officers and public servants (2017-2022) that would in effect see some earn less than before.

These were in line with job review and just concluded job evaluation. It would ensure among others fairness and harmony in remunerations of benefits. It took account of job performance, the economy and earnings adjusted to the cost of living. This hopefully captures the aspirations and hopes of Kenyans in the constitution to reduce the public wage bill. It would be unfortunate if the SRC decision was going to throw the country into another quagmire of further industrial unrests, but it did.

These drastic measures would save the country Ksh 8 billion in the first year. But then, was this a saving in a true sense since the budget was a projection of the fiscal year? We know saving = money earned but not spent. The already striking nurses (as expressed on day 38) wanted the saved Ksh 8b to be allocated to them.

What an uplifting thing that would be? But then did it matter that some of the money was going to be subtracted from them too? Every key monetary gain accrued from the industrial action and the abeyance thereof must be factored in the financial year budget.

The Chair CoG during a governor's retreat in September 2017 reiterated '…the resources are not sufficient to increase the wage bill. Nurses should be patient until the economy improves'. He added that the precedent set by the striking health workers posed a major threat to other sectors of the economy. In this respect it would be farfetched to imagine that parliament could be recalled from recess to pass a supplementary budget to benefit health care in this country!

There was uncertainty over the transition effect in the period towards and after the 2017 general election, the myriad election petitions (339 was the highest in Kenya's history so far), majorly the repeat presidential election ravaged the country's economy in a very negative way. Kenya's election was slated as one of the most expensive in the world. The electoral body alone used more than Kshs 52b [~5.2m US$] for the two elections which were only - 97days apart. The by-elections were likely to cost more since they would be spread out on a case by case basis.

The government had to review economic growth projections downwards owing to the prolonged electioneering period, cut down on unnecessary expenditure like out of the country travels by public officers. The harsh economic conditions had made the National Treasury remissions to the counties even on critical services a struggle. In any case any hoped for monetary award if at all could only be spread out, but to take effect from a date into the future. But then why was it that the state was able to honour the doctors CBA which required Ksh 8.2b for 4000 members and finding it difficult to honour nurses' 7.8b for 26,000 members?

There was very little money in circulation, stock exchange almost flopping or literally closing business more than once. Lots of consumption, little income generation, few goods and services, few to no foreign investors coming, reduced number of tourists, no payments being made to suppliers and service providers.

Safaricom® for example was reported to have made a Ksh 400m loss on the few days of the election in its Mpesa platform because agents were reluctant to transact. It was going to get worse with the ensuing economic boycott of its products and services sanctioned by the opposition leaders. According to Kenya Private Sector Alliance they lost Ksh700b in 6 months preceding the two elections of 2017. While Nairobi Stock Exchange lost Ksh 90m in the same period.

This author remembers how this became an excuse for shelving and even postponing major events, commitments and decisions. Some of these were communicated in the following format *… as you are aware we are in an unprecedented political situation that requires our response. A time to exercise our civic duty. In this respect we have decided to postpone by one month… we regret any inconvenience caused.*

Kenyans were sharply divided along political lines, this percolated lines of defence in union matters. This momentous opportunity also meant that Kenyans were more polarized than any other period. There was potential volatility in traditionally hotspot regions whichever way the election went. Lastly, there was perception of an 'evil eye' around the months of August/September as disaster prone. There was little to no service in some public offices some of it due to workers' strikes, breaks and public holidays.

There was a vicious cycle of having to rebuild the nation every 5 years which had become a reality, almost a tradition. Demographic health statistics usually took a nose dive as several gains were lost. These were not facts a union leader could afford to assume.

International Labour organization (ILO) *Convention number 98* on right to organise and collective bargaining has been domesticated to form part of Labour laws in Kenya. The two industrial actions involving KMPDU and KNUN had resulted in Kenya being indicted at ILO, summoned to appear before the health services sector tripartite committee to unravel the causes of prolonged industrial unrests within the health sector. It was a privilege being part of reforming the labour sector in Kenya.

The timing of an industrial action around such a time whether it might have been anticipated or not needs to take into account the above modifiers. In future this ought to form a critical basis for trade unionists as to whether to call for a strike at such a season but more opportune was when to change strategy if they found themselves in such a crisis. Very pessimistic huh! Well, these are all issues

for our weighting and considerations because our circumstances were unique.

Then, there was the repeat presidential election boycott followed by a post-election economic boycott by the opposition, including the secession talk and swearing in of a parallel presidency later in the year. The economic boycott for example was timed to 'escalate until the regime goes down'. The timing of strikes around elections season was awry either way in the view of this author.

[Post was shared in blog which is run by this author, See another blog post below]

Over and Out With the Kenya Nurses' Strike November 6, 2017 by CompleatNurse

The nurses' strike is over after 151 days. *Lisilo budi hubidi* paraphrased from Swahili – it was futile to resist the inevitable, and that was calling off the strike. Whether or not it had achieved the set out goal was no longer the issue. Hopefully this ends all the remaining contentious issues between the parties. The reality may be the strike is over, while the dispute may not be.

In the opinion of a good number of the striking nurses and other stakeholders, it was a matter of time before the strike dissipated. The steam had gone out of the members and the greater proportion comprised those who had resumed duty. Out of a possible 500 nurses in one particular county only 47 remained on strike.

They were coming back a battered army with bitter lessons. There were many begging question:

-How do we face betrayal, those who chickened in early, the timid who filed in at the earliest opportunity?

-How to relate with a new crop of those who had capitalized on the strike to get themselves a job?

-How to model for the new generation of nurses joining the profession?

-How to relate to every other health discipline who counted it too risky for them to be on strikeThe nurses' union still had a full in-tray. There was need to bank on the remaining goodwill to close in on the pending issues. The unfinished business included delivering the Collective Bargaining Agreement (CBA) within 30 days. Some nurses had not been on pay for the last couple of months, yet they were expected to deliver optimal care upon resuming duty. The union was expected to facilitate payments of pending salaries by 30th November 2017. Some union branches continued to ring bells of industrial action even as they resume, promising battles with their respective counties. Other counties insisted they would not pay for work not don or else did not have the money. A few had allegedly replaced the striking nurses with new ones e.g. Murang'a's 492 nurses..

Borrowing from the doctor's strike, it was not until 18th September that KMPDU had their CBA finally filed in court of law, this was 287 days after it was signed (which was 200 days since the 100 days strike began or rather 100 days after the strike was called off). The nurses' CBA if it saw the light of day, and it should was likely to deliver in staggered doses, titrated towards the next financial year. This meant time and patience with lots of give and take.

The public confidence

Even though the nurses' strike was over, many Kenyans also know that signing the CBA was one thing. Getting it implemented could be the beginning of another round of industrial action. It was unfortunate that this seemed to be the language employers understood. The current public universities lecturers' strike which resumed for the 3rd time this year was about an already concluded signed and filed in court CBA.

What about the patient? Certainly the patient had fallen through the cracks as they say. There were several gains were lost.

It will be disappointing for the public if the concerned parties were to let the matter drift towards the resumption of the total shutdown again. Instead the public should remain hopeful that a milestone had been achieved not just for the nurses but for the country's health system as well.

What had changed?



Above: Picture of an empty ward characterized most public hospitals during the nurses' strike

[Photo courtesy of citizentv]

After calling off the strike, will the nurses be going back to a more conducive working environment? Back to normal for many meant to the old improvisation, shortage of staff and stuff. More likely it was back to the same beaten infrastructure, some which had been vandalized in their absence. Problems and trials would continue.

They would be meeting a new governor in some places, and a new lot of chief officers. The counties outfit would be experimenting on several things including human resources. Trying a no-nonsense supervisor (in Swahili *nyapara* type) on nurses the way some of the county governments had started going about it would be the last straw that broke the camel's back. This would in effect emancipate the production of everyone else.
See the other posting on nurse as fulcrum.

What we could expect in the weeks ahead?

An influx of patients and clients seeking their services was obvious. The system would be strained beyond limit once again. See Health digest http://riftvalleyhealth.blogspot.co.ke/2017/11/patient-influx-overwhelm-hospital-as.html

The ripple effect of the strikes in the health sector would continue to be felt in the short and long term, in the years to come.

The promise
The promised deal that brokered the calling off the nurses' strike included:

-uniform allowance of KSh15,000, which will be increased by Sh5,000 each financial year. This allowance has been increased from the KSh10,000 they had been receiving.-a risk allowance of between KSh20,000 and Sh25,000, depending on job group, in the next financial year.

-risk allowances will be increased to KSh30,000 in the 2020/2021 financial year. A nursing allowance of between KSh15,000 and KSh20,000, to be implemented in two tranches, 60 per cent beginning January and the rest from July 2018.

The union

The nurses' union should be commended for the achievement of a return to work formula (RTWF). Nevertheless there were some prickly observations that perhaps cost the union dearly.

This is the era of emotional intelligence. I believe there was less one could achieve as a leader by 'cutting off the ears' of those representing the employer, statutory bodies or institutions set by the constitution for that matter.

Arguments may not always be won on the basis of what was said, but people watch the how, the manner one responds to those who they disagree with without going overboard. They will respect or thank you for expressing yourself in a thoughtful manner. As a result they too were likely to support your effort and increase your reach without questioning your ability to lead.

'Fire spitting', "flapping in the air" and infighting officials could have derided the image of the profession more than enhanced it. This could result in a low trust ranking of information coming from the union and association concerning health policy issues in the future.

Unionist posturing in politics would continue to hurt it for some time. But then the leaders had no one but ourselves to blame, that's the nature of Kenyans. Political proofing of union issues was going to be a big task going forward. Playing victim would not work. Union issues are political issues some argue, nevertheless it makes sense to run with the government in power at any given time. After all it is the employer. They say in nursing school the instructor and the textbook are always right. Even when they disagree.It was upon the student to know which one of them was right there (when).Rebuilding the nurses' union would be necessary, perhaps usher in a new crop of visionaries. Those who could create some optimism in order to command the same or a better following next time. Certainly there would be a next time some short distance away.

Take a rest

After calling off the strike, it was realistic to expect the nurses to take a rest from social media. Not throwing in whatever post and comment as had been witnessed during the strike. Voices of reason were likely to persist or take over in a more sober manner. Hopefully they would make it their priority to heal the divisions within the nursing fraternity using a methodological and deliberate approach. Try and put this ghost to rest sometime soon.

It was expected that there would be a push and pull favouring out-migration especially among the younger, specialized nurses. Undisclosed sources had indicated that a handful of them were waiting on the wings; to take the factored accumulated arrears (if it ever came) in one hand and resign from public sector with the other.

Lessons learnt

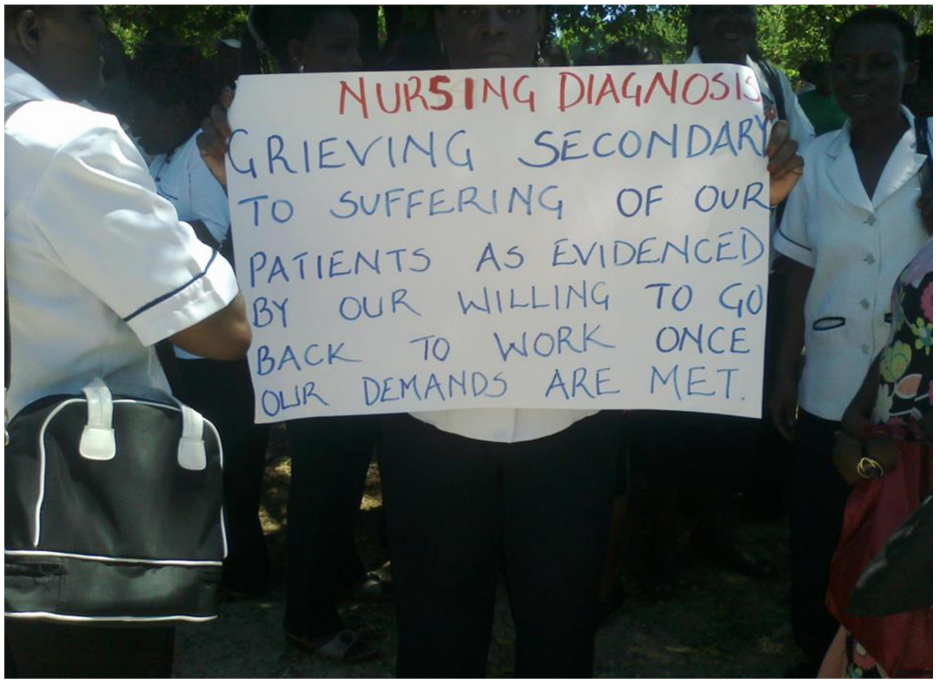
There were numerous lessons learnt from the just called off strike. Seemingly there was some disproportionate negative energy among the striking unionisable comrades in relation to the gains accrued from the strike.

To this extent some pundits felt that after 100 days the doctors finally settled for (more or less) what the government had offered them on Day 2 of the strike. It would not be surprising if the nurses had followed suit and took the risk allowance and uniform allowances and RTWF they had been offered on 5th June (or rather Day 1 of the resumed strike). But then it was not all about the money, it was about a better health system.

The other reality was that there was a lot of work in progress with devolved health care with no low hanging fruits for county public service board employees (including nurses). It makes sense to also see the harsh economic and political realities the country was going through.

The timing of the last industrial action whether it might have been anticipated or not was a fodder for drawing some lessons. In future this ought to form a critical basis for trade unionists as to whether to call for a strike at such a season. But more opportune was when to change strategy if they found themselves in such a crisis. Calling for 'a mother of all strikes' in the health sector many will agree was not tenable in future although it cannot be ruled out.

What do you see in the times ahead? Do you feel it is over and out as far with the nurses' strike?



Pic: Some of the innuendos during the industrial action by health care providers Courtesy of the Nurses website

The section (3.3.0 ♯HealthCrisisKE Diaries) above is an exerpt from this author's diary that followed up innuendos there about the happenings during the doctors' and later the nurses' strike of 2017. Chapter 17 of this book is a dedicated to *The Future of Nursing*.

3.3.1 Devolution of Health Services: Why the Bad blood?

The devolved health structure was the first major step towards providing healthcare to all Kenyans. In essence the letter and spirit of devolution according to World Bank, (2001) was that "Devolution is a form of decentralization, or the transfer of authority and responsibility from central to lower levels of government for a range of public functions".

Health had become a shared function, devolved units were now responsible for critical government functions, therefore devolution's success relied heavily on ongoing political will at all levels of the government. For example the desire for improved health outcomes is one of many factors driving political will for health sector devolution.

The health function is critical to the welfare and prosperity of any nation. A county's health budget was determined by the amount of money it received from the national government, how much its treasury allocated to health, and how much revenue the county was able to raise from local taxes.

Spending was mainly driven by historical trends and less ideally on strategic plans. Counties claimed that they were using less allocation on development and more on salaries for the 'bloated' workforce they inherited from the national government. (Counties retained all health workers employed before devolution in March 2013 at their former salaries and benefits packages). Yet several counties were not hesitant to use half or more of the little development resources on constructions, it hardly mattered whether they would get completed, equipped and manned.

Bad blood it seemed was a matter of interpretation, who was doing it and conveniently so. According to the Institute of Economic Affairs (IEA) in the 2012/2013 FY counties were probably given Kshs 55.1b. Further it is to be underscored that counties make their own choices about health allocations, so they may spend more or less than the national government on health. Did the counties really spend that amount on health? Or maybe the national treasury did not actually transfer that amount on its totality. The IEA is a public policy think tank.

Since 2013, there was some continued bad blood between County Governors and the central government over allocation of resources, the Governors demanding more while the central government demanded for accountability of what had already been released. Previously, there was even a call in support for a fresh referendum with 'Pesa mashinani' campaign which translated from Swahili means 'money to the grassroots' among other contentious issues. This had been gaining momentum and it would be a matter of time before Kenya goes through another YES/NO referendum on this and other matters.

County governments were pushing for a 45 per cent of national revenue devolved to counties. But by early 2015 the national treasury threatened to deny them increased allocation to devolved units that had apparently mismanaged previously allocated funds.

By conceptualization it had been expected that in 3 years of devolution counties would gradually build capacities, have functions such as costing unbundled meticulously. Health was a shared function as per the constitution. It was expected that counties should first have taken over preventive, promotive care which included primary health care activities, health centres and dispensaries. These were to be piloted before taking on larger facilities. Instead of this, things happened so fast.

Governors wanted a lot of work and the national government let go against the recommendations of Commission of Transitional Authority, 2012. One disappointed observer noted, 'it was not supposed to have been taking over from where the other one left, but from where they were and carry on'. She added, 'it was like dropping a 'ball pap!''

Problem holder's nolonger existed unlike before. It was believed that there were previously unappreciated and unexplained attributes of the national government that used to cushion and adsorb many things such as staff unrest. Devolution of health was a great idea that had not been well implemented.

This author could not help feeling like our government needed to work smarter to improve the provisions under the devolved plan that we now had, instead of constantly locking horns over its existence. Disbursement of funds from the national treasury was done on a monthly basis over the 12 month period.

For example 2014/2015 one such county received Ksh 340million from the national treasury that month. Ksh 150 million from this went to payment of salaries; 30million

went to payment of elders' stipends and Ksh 10 -12million to all statutory deductions within the county.

Whatever remained (Ksh 120million), was too little to be distributed over all the departments and ministries for development projects. This was because some development projects had been approximated to cost over 50% of the total monthly disbursement to the county from the national treasury.

The County Governors had snubbed the medical equipment launch function presided over by President Uhuru Kenyatta at State House, Nairobi on 6th February, 2015 with signing of a 38 billion shillings contract to facilitate the equipping of two hospitals per county with state-of-the-art medical equipment in all of the 47 devolved units (about 94 hospitals in total).

The president who presided over the ceremony at statehouse said the project was geared towards ensuring that the constitutional right of Kenyans to access the highest attainable standards of health regardless of their location was met. It was understood that the county bosses were angry at the Health Ministry for not furnishing them with details of the project. They were also worried at the bulk of the health services being devolved, and that they would be blamed if the project failed.

It was believed that governors preferred to handle the procurement themselves. The then chair council of governors' had said their concerns were on whether the equipment provided was bought or had been leased. Interesting the same governor had practically demonstrated that leasing ambulances for his county was more cost effective than buying them. Doublespeak was a fairly common phenomenon among elected leaders who were vested with major decisions including health.

The government had signed multiyear contracts through the Managed Equipment Services (MES) model with five multinational companies for the supply, capacity building, installation, operation and maintenance of the equipment.

Mindray Biomedical® from China would supply the theatre equipment, *Esteem®* from India the devices, equipment and consumables for theatres, *Belico SRL*® from Italy the dialysis machines, *Philips*® from the Netherlands the Intensive Care Units and *General Electric*® from the US the radiology machines. This perhaps gave the government greater flexibility over time.

The government would pay when and if 'the outcomes were good and the equipment functioned'. Surely, one would argue it was no good to get stuck with capital equipment that gets obsolete in 4 years … hiring seemed a better option.

The cancer treatment equipment would cost KSh21.8 billion, the renal ones KSh2.2 billion, the ICU equipment KSh3.3 billion, the theatres Sh12 billion and the laboratory equipment - which would be tendered at a later date - KSh2.7 billion. This would ease the patient load on Kenyatta National Hospital and Moi Teaching and Referral Hospital, the only public hospitals capable of handling cancer and kidney problems. Currently it took a patient 2 to 3 years for patients to access radiotherapy treatment at KNH in what was christened *patient plus patience*[41]. The waiting list usually has over 1000 patients at any one time. KNH had only 3 machines, It was regrettable that KNH apparently had not been included to benefit from the MES project.

After being taken through a *state of art* Radiology Unit in one of the early adaptors who had installed and started using them the equipment included: digital X-ray, digital

mammograph, OPG (orthopantogram) mainly for dental images, digital mobile X-ray unit for ICU with Wi-Fi, teleradiology picture communication system conference (PACs) capable of linking experts who were distances apart, across counties and beyond to consult/discuss image(s), C-Arm image intensifier that takes real time images during theatre operations, 2 D (possibility to upgrade to 3 D) ultrasound with accessories for transvaginal, transrectal, Doppler, superficial and general.
A Safaricom® mast was used to transmit the signals voice and data. The advantages have been: due to reduced turnaround time (TAT) thus reduced waiting time by half referrals from private facilities, no darkroom (utilizing CD disks not films), was more comfortable to work with.

Anyone remembers the Government of Kenya – Italian/Spanish/JICA initiatives of the1990s? May be some remote memory about equipment supplied by *Icuatro* in the 90s? The *Ivecos*? The health sector received critical care equipment, ambulances, Xrays, Ultrasounds etc. Some of the 'state of art' equipment was dispatched to the then district and sub-district hospitals. A great deal of these never got to work. A colossal number of them were not switched 'ON' e.g. Blood Gas Analysers (BGA) that were never commissioned.

It was unimaginable but it happened that a government project could procure cardiac defibrillators which did not have an inbuilt ECG/EKG (electrocardiogram screen) monitor - likely this was some obsolete technology. Relying on or building on 'soon to be or almost' obsolete technology had stifled the lifecycle of some noble projects.

Is it like history was about to be repeated? The same stuff being flaunted today just like those days. This time we believe they will turn around the health sector, and hopefully they should. The question is: What else could have changed except the credit of time and hiring?

There was need for a customized feasibility study to determine needs of different counties. It had been observed from this latest MES project that in some cases equipment was delivered to several counties which did not have the expertize to handle them. Some of these had difficulty retaining general health services staff let alone specialists. Yet each county was expected to pay Ksh 1m annually towards servicing MES debt. This was money they could have channelled to their priority areas some felt.

Some areas lacked in very basic consumables and drugs e.g. imagine lacking Oxytocin injection for prevention and management of post-partum haemorrhage (PPH). At other times equipment may have been delivered to places that already had them or to areas where the prevalent diseases required something different.

All these were great plans with noble intentions but without involvement, this was where we often see great plans go wrong and Kenya has had a number of *white elephant* projects in the past. It was easy to look ahead at the outcome, but it takes work to get there. History tended to repeat itself in matters integrity in Kenya. By June 2018, The Auditor General had raised queries concerning overpricing and cutting corners on the MES program. Accounting and procurement officers in the Ministry of Health were being probed by Parliamentary Accounts Committee (PAC) as to why 37 CT Scanners were bought at Ksh 227 Million Each instead of market price of Ksh 45 million.

[41]KTN PRIME Patients +Patience, 21Hrs, 2nd May 2015

One of my favorite quotes by Thomas Edison states, "Opportunity is missed by most people because it is dressed in overalls and looks like work." It takes work to make change possible. Until our leaders were actively willing participate, to be at the forefront of change, it will continue to be ideas on paper.

By just looking at the constitution, after the protagonists had argued their case either way one was left wondering what the intentions of panellists during the constitutional making process before 2010 could have been. It provided fodder that made for great news media coverage in what could best be described as 24/7 hyperdrive.

The trend had been that what 'bleeds' often led in terms of news coverage but not what answered to Kenyans' needs. The good in health care had to be really sensational as to be celebrated in order to attract some media coverage.

3.3.2 Politicking around

The devolved structures were not perfect but in time they would improve. It needed a lot of goodwill, love and attention if it was going to be successful, but our politicians were so busy jockeying for votes. Bickering for power was a common development in Africa that led to serious uncertainties cutting on social pillars such as health.

Much as health was a viable currency for political negotiation it was a vulnerable service industry. Ever dangerously close to the precipice of collapse, destroying the gains made every 5 years. Strikes by health care workers in Kenya somehow coincided with general elections. May be the stakes seem to get higher as the trade unions sought for sympathy from political players.

It was known as reported by Sisaye (2009), Shikanga (2009) among others, that gains painstakingly made in areas like: health infrastructure, health literacy, family planning, fight against HIVAIDS, ARV adherence, gender based violence, nutrition, sanitation etc. got eroded during periods of instability, yet every other election was a potential flashpoint for violence.

Vulnerable populations: children, adolescents, the aged, the sick and women suffered the most. Violence or perceptions of it was usually signalled by allegations of election fraud which led to dislocation, forcible transfer of populations, internally displaced persons (including profiling and intimidation of health care workers not indigenous of the area they were deployed). Create a fear of the unknown narrative so that these people would not vote at all or 'vote and go upcountry/out of the country'. It happened in Kawangware suburbs in the outskirts of Nairobi in October 2017.

Neighbours turned against each other. As unethical as it was it was not unusual for public officers to take sides. Crowded living situations, lowered levels of personal hygiene and inadequate sanitation due to large geographic shifts of the population meant that disease outbreaks became a big challenge to contain during periods of political instability.

> "Lack of public transportation, multiple work stoppage "mass action" days, and impromptu roadblocks on rural roads, greatly complicating access to health facilities…Many staff in health facilities…who had left their posts to go to their home areas to vote and celebrate Christmas were unable to return.
>
> Health facility staff of rival ethnic backgrounds also fled their posts…out of

> concern for their personal safety. Health facilities experienced shortages in critical supplies during the months after the election…Staff and supply shortages were most acute in January and February during the height of the post-election violence, but persisted into March and April…." (Shikanga *et al*., 2009, p.1088).
>
> Hiding under the beds trembling, lights off as election violence rages down the streets due to old politics of horse trading, back stabbing and ethnic baiting as they rally and circle the wagons to protect their turfs. (Posted by a popular daily columnist). See short video link here.
>
> 'We are busy fighting for our leaders while whenever they have a reason to, they jointly fight us…' WN on Social media Enlightening Nurses on 28th September 2017 when the newly elected members of the 12th parliament made it their first agenda to fight for better pay, reverse SRC guidelines capping their numerous allowances and comprehensive medical cover for themselves and their extended families 'read concubines'. All this time the national nurses' strike entering its 4th month. This was a month to the repeat presidential election and there was palpable tension in the country.

A good number of displaced persons never came back. Many patients especially on ARVs were found to have not returned to their routine health facility after the conflict. Achieving the optimal pre-election staff numbers became an uphill task for a couple of years later. Some regions reported more than 45% deficit compared to pre-conflict levels. Communities and care providers that did come back struggled to rebuild, pre-existing ethnic cleavages that had deepened.

It was important to underscore that it is what happens between elections that counted the most. In most instances however Kenya was an 'all-time electioneering' mood country characterized by anxiety and unpredictability around each election cycle. In a way not letting go to allow Kenyans move forward with their lives. Pointers to these otherwise referred as *mihemko na mirindimo ya kisiasa,* www.MyMemory.net direct translation from Swahili for *emotions and thunderings of politics*.

Some political leaders at some point threatened 'we cannot be part of an election where those that matter more were those who count the votes and not those who vote' and 'if the court rules not in our favour, there will be no elections…' The ruling was a win for Kenyans or rather went in their favour, but it was not hard to imagine what the effect would have been. The perceived interference with the independence of judiciary, the election body, inspector general of police etc. was a bad precedence. Or else what security experts called 'playing political goals with national security'(and health), elevating political considerations and implications above enforcement of law and order considerations.

It was reported that the spate of anti-IEBC (Independent Electoral & Boundaries Commission) protests in mid-2016 led to each business in central business district of Nairobi city losing an estimated Kshs 48,000 daily or rather every 'teargas' Monday that the protests were on. Workers did not show up to work and it was unimaginable which other sectors including health suffered. These were followed closely by anti-EACC Ethics Anti-corruption Commission protests in August 2016.

There were renewed anti-IEBC protests in the run up to the repeat presidential election in 2017. It was unfortunate that this was happening alongside the over 5 month's national nurses' strike, with each group easing up space for the other in order to allow them hold their grand demos on alternate days in terms of the manner, time and place.

The political class were willing to risk the healthcare of 45 million Kenyans. I think it is unbelievably unfair, and stands in the way of real improvement to health care. Politicians were getting people all worked up but were yet to provide alternatives to the problems ailing the country making everyone believe that the State of the Nation overshadowed the health of the nation.

The political class had an overbearing role in terms of the health system in any country. Let us consider the following example about disaster management:

According to Mr Houghton, the executive director at Society for International Development, 'emergencies are spontaneous, but emergency care shouldn't be'. More needs to be done to ensure emergency services are an integral component of the healthcare system in the country.

Disasters were somehow interlinked with disruption of even efficient health care systems. Kenya had suffered droughts and famines, terrorism attacks, floods, post-election violence among others. For resource constrained settings many times disaster came to stretch the precarious fabric that held together the little that there was. Let us consider the Disaster Bill 2016 for a moment.

From the 2000s to date this bill was yet to see the light of day. It had gone through twists and turns to 'to perfect it', to accommodate emerging and re-emerging issues including: the Constitution 2010, terrorism, interests of various regimes and even the interests of some development partners among others.

Currently different agencies had been set up to address disaster issues. Some were under different line ministries. These included National Disaster Operation Centre, National Disaster Management unit, Drought Management Unit. We can add the well-meaning Kenya Red Cross and other nongovernment organizations etc.

Whose interests were they serving, one wonders? A lot of their efforts often lacked direction, were adhoc with little tie to each other. However in mid-2017 in the run up to the general election, the first ever congregation of these multi-agencies and the security organs conducted a rapid response capability exercise at Embakasi Humanitarian Peace Support School.

Winston Churchill once said we should never squander a disaster. We should draw valuable lessons from each. But even with a trail of disasters for 17 years of the draft it seemed Kenya was not any closer to a national disaster management policy. The 11th parliament had likewise squandered the chance even after Hon. Tiyah Galgalo (the Isiolo Women Representative) sponsored the motion in December 2016.

If this bill ever became law, a national outfit would coordinate interventions; improve access to assistance, risk management, risk awareness, disaster reduction, disaster prevention, preparedness, mitigation and ultimately health etc.

The policy once in place would make Kenya able to mobilize resources during a disaster, for example it would be eligible for World Bank loan within 24 hours of a disaster happening. The policy would ensure compulsory reserve accounts for disaster related issues that were jealously protected. As it is the political class would nolonger treat it as 'idle' money, or be eager to spend it. This would remove the pressure and temptation to flaunt the money for political mileage. These were some of the low hanging fruits the

country had denied itself for this long, Imagine the difference it would have made during the 2018 floods tragedies including the Solai Patel's Dam burst that killed about 50 people and displaced hundreds of others.What of the now too regular poorly done storey buildings collapsing trapping people whose lives could have been saved?

Talking of floods, during an educational tour of flood prone areas of Bundalangi and Port Victoria in Busia County. We were taken round the dykes that had been constructed to keep off river Nzoia from breaking its banks. Interestingly, the both the northern and southern dykes stopped at the exact border point of Busia and Siaya Counties, not an inch longer while the river continued. Our guide wondered why like everybody else they did not need a dyke in Siaya. The only explanation was that Siaya was on the upper zone of the river but then we hardly noticed the undulating gradient for as far as our eyes could see, it looked the same to us.

Kaplan and Garrick taught that risk analysis consisted of answering three specific questions:

1. What can happen?
2. What is the chance that it will happen?
3. If it happens, what are the consequences?

The health related challenges were the same (perhaps higher in Busia) in this order: floods, malaria, cholera, HIV/AIDS and child labour among others. A plan to mitigate the floods by constructing dams in Butere and other sub counties upstream had been rejected vehemently. Could these have been political decisions? You see political decisions even ten steps away ultimately affected health one way or the other.

Kenya's health sector had been an easy target for election campaign promises. In the run up to August 8th, 2017 rival political coalitions promised that if elected there would be universal health care by 2020, NHIF cover for mother and child for one year, free maternity care etc. They were attractive offers and certainly, these could ease the financial burdens of millions of vulnerable families. But it was also clear that not a lot of thought had gone into some of these ideas. Kenyans needed to interrogate these in a controlled environment other than from campaign platforms and manifestos.

The electorate should be wary of bold health sector reforms promises other than articulating issues which were deliverable. They should demand to know the hows, if the country was ready or able to offer the same. These were the only ways they could hold the leaders to account. (See **An essay** below).

An essay: Why were there no medicines in Kenyan hospitals if there was so much else to show off?

Post shared by blog
http://www.compleathealthsystems.com/

As a voter and health care provider, I wonder why there were no medicines in Kenyan public hospitals if there was so much else to show off. I will start by explaining the showiness, then why some of our priorities were upside down.

In one senatorial by-election in the recent years, the campaign was very hot and it seemed the stakes were high. The campaign team of one candidate in their wisdom saw that they needed to do a land to air onslaught. So they came in contingents of top of the range big blue/black cars the popularly known as: Landcruiser *Vx/Zx/Tz/V6/V8*, Prado Teardrop and Mercs etc. Dust rose all around, high output public address stereo speakers bellowed the landscape, the air was ionized and could easily be ignited with a rhetoric song in praise of the political party and candidate. Business came to a standstill.

They hovered over the territory in six choppers (helicopters) and more cars on the roads or was it more roads with more cars? During some of the meetings the six choppers could be seen neatly packed in the stadium. One media house titled it: *Chopp my money*.

Cost: In 2017 it was reported that there were 88 registered helicopters in Kenya. A new one was costing Ksh 600m and a second hand Ksh 340m or thereabout. It cost Ksh 170,000 per hour to hire one helicopter. For 12 hours that would be Ksh 2,040,000×6 choppers=12,240,000x7days=85,680,000. That is Ksh 85.68m in just one week for the choppers alone. That was more than enough time/money for one day. [1USD =120Ksh].



[Choppers neatly parked before a campaign rally. A helicopter has become the status symbol in today's politics. PHOTO | FILE | NATION MEDIA GROUP]

The wananchi (to mean citizens or residents) were amazed, some on barefoot, enthralled and cheered on the showy politicians. They greeted them (or accepted unsustainable tokens) with a supported handshake. They could not see through the hoodwinking, the lies and the hypocrisy of politicians. Others in consternation were put off by this presumptuous consumption. Either way, as a result, they delivered the votes, period!

Then it was all quiet again, the land rested. Could be that the candidate won and the people lost. I think that's it, because even the oversold promises could not live. Some promises sounded and looked good but didn't make sense. May be this saying was true about some politicians, 'you should always say what you mean not'. But it didn't matter; they could always be reincarnated, revived, rehearsed in the next election, posturing with more sweeteners for mwananchi. It had been observed from various quarters that Kenya was generally a political economy and politics was about personality, propaganda and seducing the masses. Some even spurring confrontations among the people. Lots of stuff was written by political protagonists, confusing the public further, because 'politics sells'.

Corrupting decisions made by the citizens through misinformation and propaganda or hyping on people's ignorance was the wrong thing to do. Neither was defending positions nor showing how we got to where we were without offering tangible solutions to help the residents. If people could see through (even by simple commonsense) who among them was believable, could deliver. Who could they trust with their health, safety, their life?

Kenyans elections were among the most costly in the world. The two elections in 2017 would cost the taxpayer Ksh 52b, it was estimated then one needed Ksh 40m to seek an election post (anything up from woman representative, senatorial, Member of Parliament, to gubernatorial) in Kenya for the campaign alone. May be that was why the Kligler Commission that had investigated post-election violence in 2008 had proposed an Election Finance Act.

In the interest of basic fairness and equity something was wrong somewhere. All these times the mwananchi continued to complain there were no medicines in the hospitals. If such a fund (Ksh 86m per week) were to be injected into the health care system it could do wonders. At that particular time in the case above, the county referral hospital's busy Sick Child Clinic there was only diarhoeal treatment salts – Zinc element (*dts*-Z kit), syrup paracetamol, and injection adrenaline and injection hydrocortisone in stock.

Kenyans were supreme and sovereign. Leaders must not have a sense of entitlement, throwing around their weight for the wananchi to notice. They even expect the public to excuse their offences and transgressions. They are eager to start something fresh, including controversies so that they can become popular, chest thump and ask for votes in return. Kenyans will need to learn to exercise their duty to vote in transformational leaders with a conscience.

There was this commentator on a popular music competition TV show that run by the name of Americans got talent who stopped the buck where it belonged – voting in the winner, 'Americans can't just let it be, they have to vote…with a clarion call to – 'Let your voice and vote count'. There is something everyone can do so that we can have something for everyone.

In conclusion, we ask why were there no medicines in Kenyan hospitals if there was so much else to show off?

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CHAPTER 4

Models on Access to Health Care

Overview

In this chapter, various models and frameworks on access to quality health care are reviewed for evidence by employing an integrated review. Models and frameworks should allow implementers to be innovative, creative, and experiment, and provide them the chance to see what the different approaches can give them (Technical report, 2013).

Those covered here include: *Penchansky's Model*; The Institute of Medicine (IOM) *Model of Access Monitoring*; *The Behavioral Model of Health Services Use;* Andersen and Newman *Framework of Health Services Utilization*; *Conceptual Model to Assess the Underlying Factor* and *Kenya Health Policy Framework 2014-2030* among others. The existence of the shortcomings identified in one model does not imply that the processes should be abandoned. Instead, improvement needs to be done to enhance them.

There was need to strengthen institutional processes in which decisions to adopt the models/frameworks are taken as well as the individual health care providers. The proposed 'Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS)' seeks to add value in the two areas.

In June 2013, a 3 day seminar brought together key Kenyan stakeholders and health care quality leaders from other countries to share experiences and ideas on successful models for leading and supporting improvement of health care at all levels of the health system. Some of these deliberations have been captured here. The BUZZ internationally is quality "Universal Health Care Coverage" courtesy of HFP-UHC WHO online course will he covered in section 4.9.2 of this chapter. A small review of the public private partnership strategy has been presented in section 4.9.6 below.

4.1 Evidence for Models on Access to Health Care

The search strategy for models and frameworks employed in this integrative review was undefined and depended more on links due to erratic results from the search engines. Attempt to use the databases like CINHAL did not prove useful either. An editorial by a quality health journal also attested to this challenge (Saturno, 1999).

Three models on access were reviewed by Karikari-Martin (2010). They have been used to inform health policy in the US. These models include: (a) The Institute of Medicine (IOM) Model of Access Monitoring (b) Penchansky's Model (c) The Behavioral Model of Health Services Use. Each model uniquely evaluates different health policies.

4.2 Penchansky's Model

The Penchansky's model (1981) defined the concept of access and the relationship to consumer satisfaction. It outlines access as major concern in health policy with '…access being one of the most frequently used words in discussions of health care system'. Penchansky and Thomas dealt with issues of ability to pay charges for health care services. It is useful when subjective experiences with health care access are needed to

inform policy makers. Penchansky's model has not been used significantly to monitor or evaluate quality or cost of services. However, if the overall policy goal is to improve consumer satisfaction among a specific group of people, then Penchansky's model is a good fit (Karikari-Martin, 2010).

4.3 Institute of Medicine (IOM) Model of Access Monitoring

The IOM (also covered in Chapter 1) published the Institute of Medicine (IOM) Model of Access Monitoring of a health care system which laid out six "STEEEP aims for improvement" (as outlined below) as a useful blueprint that could help guide decisions about what aspects of care to measure:-

*Safe (**S**)*: The system should be safe (i.e., free from accidental injury) for all patients, in all processes, all the time. For example, there should not be lower standards of safety on public holidays, weekends or nights. Patients should only need to tell their health care providers information once, and health information should not be misplaced, lost or overlooked.

*Timely (**T**):* The system should deliver care in a timely manner (i.e. without having to wait on long queues that were wasteful and often anxiety-provoking). This domain addressed access issues.

*Effective (**E**)*: The system should provide care that was effective, based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcomes. This domain concentrated on the appropriateness of care (i.e., care that was indicated, was as prescribed by protocols or was it given as per the clinical condition of the patient?) and addressed the problems of over use and underutilization of health care services.

*Efficient (**E**):* The system should be efficient (i.e., use resources to obtain the best value for the money spent). This IOM domain addresses the underlying variation in resource utilization in the health care system and the associated costs.

*Equitable (**E**):* The system should be equitable, meaning that care should be based on an individual client's needs, not on personal characteristics (such as gender, race, or insurance status) that are unrelated to the patient's condition or to the reason for seeking care. Health disparities are defined as differences in treatment provided to members of different racial or ethnic groups that are not justified by the underlying health conditions or treatment preferences of patients.

*Patient-Centred (**P**):* The system should be patient-centred. This concept encompasses the following: respect for patients' cultural values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support (i.e., relieving fear and anxiety); and involvement of family, significant others and friends.

An ideal patient care environment ought to be able to measure all the six "STEEEP aims for improvement" IOM domains. The IOM model was used for monitoring quality of health care services provided by linking the concepts quality, cost, and outcomes.

The model describes a dynamic relationship between the variable: cost (a patient barrier) and quality. Furthermore, the IOM model clearly defined quality as care that meets defined standards of appropriateness. This model is certainly a good fit to guide health policy studies interested in quality, cost, and outcomes if the indicators can be measured and analyzed within a short time. This model would be relevant in many ways to the Kenya health care system (Karikari-Martin, 2010).

4.4 The Behavioral Model

The model of the '70s and '80s had proposed that utilization was a function of a predisposition by people to use health services, factors that enable or impede use and their need for care. The Behavioral Model was designed with several purposes: (i) to understand why families use health services. (ii) to define and measure equitable access to health care. (iii) to assist in developing policies to promote equitable access (Aday, 1974 & Aday, 1980).

The Behavioral Model identified explanatory/predictive factors associated with utilization of services. The linkage between quality, cost, and outcomes, which is of great interest in health policy, was not sufficiently represented in the Behavioral Model. However, the Behavioral Model described access outcome as a measure of the degree to which effective and efficient access is achieved once the person enters the system. If the objective is to increase effective and efficient use of health services, the Behavioral Model would serve as a good framework (Karikari-Martin, 2010).

In community health the model provides a key theory to explain use of resources and health promotion while for those who are managers in "institutional" settings it is valuable for understanding how individuals select health care services. Two indicators—insurance coverage and effective/efficient provision of services—are captured in the Behavioral Model's enabling factors and access outcomes. Originally the model focused on the family as the unit of analysis (Ferketich, Phillips, & Verran, 1990). The outcome of the original model was health service use. In subsequent work the focus shifted to the individual user.

Predisposing factors in the Behavioral model for health care utilization included: Demographic factors such as age and gender; Social Structure includes education, occupation, ethnicity, social networks and culture; Health Beliefs: attitudes, values and knowledge that people have about health and health services; Need included how people view their general health as well as the judgment of whether symptoms require professional health care (compare with Health Belief Model below).

Enabling factors in the Behavioral model for health care utilization included both community and personal resources: available health personnel and facilities, individual means and know-how to get services (income, insurance, transportation etc.).

Ferketich, Phillips, & Verran, (1990) project using the Behavioral Health Model was called the Comprehensive Nursing Practice Model for Rural Hispanics, better known as CMLNP (pronounced *Sim-el-nip*). The survey was designed to describe its use with the household as the focus. Its unit of analysis was the individual household - not the family, but the health of everyone living permanently in the homes surveyed.

They implemented an innovative nursing practice model for health care delivery in four rural Arizona communities in the US. (Please see Appendix 11). As part of the project they developed and conducted a health survey of utilization at three points in time.

The Model used in CMLNP was a composite that developed in Phases 1 and 2 of the Behavior Model. It proposed that predisposing factors of demographic characteristics, social factors and health beliefs would have an influence on enabling factors.

Enabling factors of financial status and perceived accessibility (e.g. transportation) and availability of health services would influence the perceived need for services. That perceived need as indexed by a self-assessment of general health and need for service would affect the actual utilization of services and satisfaction with care.



Picture: Members of public wait for services at a Dispensary (Picture courtesy of NASCOP treatment consultative conference, Nov 2013)

Utilization of services was measured by actual use of services and a pattern of health care was evidenced by health promotion activities. While satisfaction was measured as two types: - (i) satisfaction with services in general and, (ii) satisfaction with care received on the last health care visit.

According to Ferketich (1990) some constructs that were missing from the Phase 2 development of Behavioral Model were aspects such as Policy, Resources and Organization of the Health Care System. In the CMLNP model availability of resources was included under Enabling factors.

4.5 The Health Belief Model

The Health Belief Model (HBM) by Rosenstock in 1966 revised by Becker (1976, 1978) became a popular framework in studies focusing on patient compliance and preventive healthcare practices (See appendix XV). The model postulates that health-seeking behavior is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing that threat.

The major components of the HBM include: perceived susceptibility, perceived severity, perceived benefits and costs, motivation, and enabling or modifying factors. Perceived susceptibility is a person's perception that a health problem is personally relevant or that a diagnosis is accurate.

Even when one recognized personal susceptibility, action would not occur unless the individual perceived the severity to be high enough to have serious implications. Perceived benefits were that the patients' beliefs that a given treatment would cure the illness or help prevent it, and perceived barriers included the complexity, duration, and accessibility of the treatment.

In this model motivation is the desire to comply with a treatment. Among the modifying factors that have been identified are personality variables, patient satisfaction, and socio-demographic factors

4.6 Andersen and Newman Framework of Health Services Utilization

The purpose of this framework was to discover conditions that either facilitated or impeded health services utilization (Andersen and Newman, 1995).

The goal was to develop a behavioural model that would provide measures of access to medical care and bore striking similarities to behavioural model already covered (Aday, 1980). The Framework of Health Services Utilization was first developed in the 1960s and has since gone through several phases.

Briefly, in Andersen and Newman Framework (revisited in 1995) an individual's access to and use of health services is considered to be a function of three characteristics:-

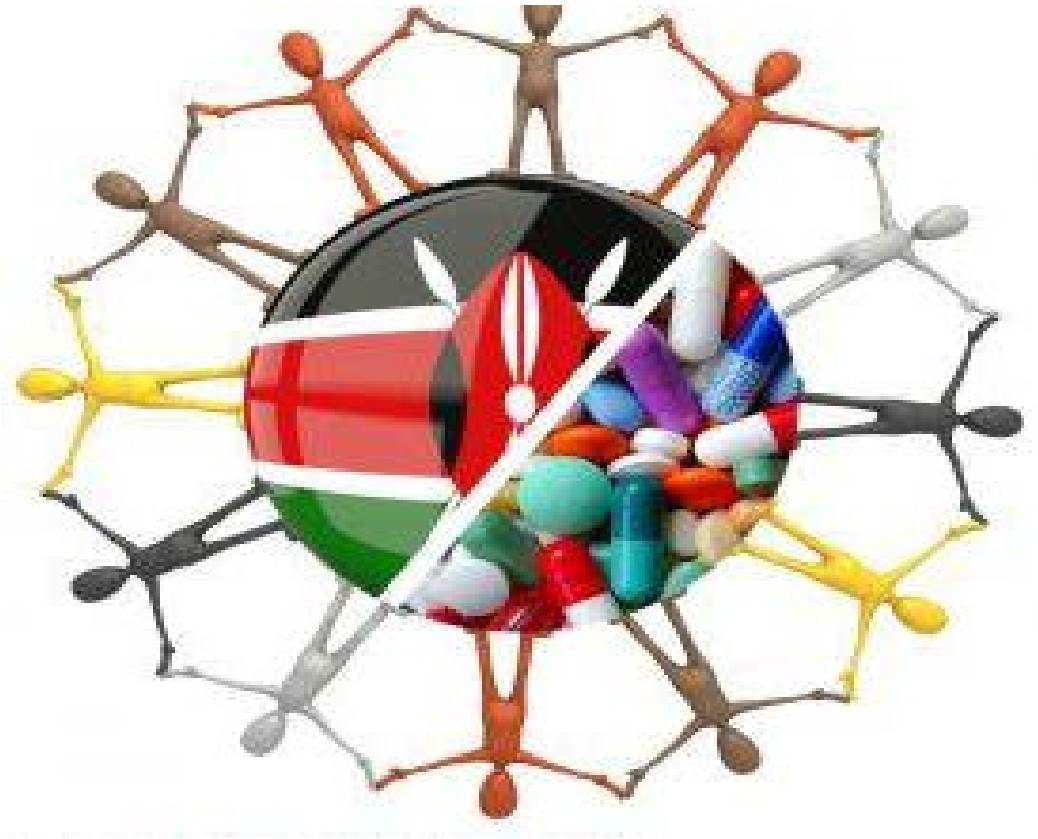
a) Predisposing Factors: The socio-cultural characteristics of individuals that existed prior to their illness e.g., (i) Social structure: education, occupation, ethnicity, social networks, social interactions, and culture. (ii) Health beliefs: attitudes, values, and knowledge that people have concerning and towards the health care system (iii) Demographic: age and gender (compare with Health Belief Model appendix XV)

b) Enabling Factors: The logistical aspects of obtaining care (i) Personal/family: The means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships. (ii) Community: Available health personnel and facilities, and waiting time. (iii) Possible additions: Genetic factors and psychological characteristics

c) Need Factors: The most immediate cause of health service use, from functional and health problems that generate the (perceived or evaluated) need for health care services. Perceived need being the subjective view by the client while evaluated need is as per the health care workers' judgment of the health of a client or population they serve.

4.7 Conceptual Model to Assess the Underlying Factors, Access to Health Care

Hossain and Laditka (2009), by using generalized spatial structural equation modelling attempted to identify how population lifestyle, physician practice behaviours, population tendency to use health care resources, and disease prevalence were associated with access to primary health care, as measured by hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). They observed that counties in USA having low access to primary health care also had unhealthful lifestyles, inadequate physician practice behaviours, a low tendency to use health care and high rates of disease prevalence (Please see Appendix 111).



Schema: Healthcare must be everybody's business in Kenya
[Courtesy of www.africahealthreport.com]

Table 1. Five Dimensions of Access to Health Care Services

Dimension	Questions
Availability: The existing health services and goods meet clients' needs.	What types of services exist? Which organizations offer these services? Is there enough skilled personnel? Do the offered products and services correspond with the needs of poor people? Do the supplies suffice to cover the demand?
Accessibility: The location of supply is in line with the location of clients.	What is the geographical distance between the services and the homes of the intended users? By what means of transport can they be reached? How much time does it take?
Affordability: The prices of services fit the clients' income and ability to pay.	What are the direct costs of the services and the products delivered through the services? What are the indirect costs in terms of transportation, lost time and income, bribes, and other "unofficial" charges?
Adequacy: The organization of health care meets the clients' expectations.	How are the services organized? Does the organizational set up meet the patients' expectations? Do the opening hours match with schedules of the clients, for instance the daily work schedule of small-scale farmers? Are the facilities clean and well kept?
Acceptability: The characteristics of providers match with those of the clients.	Does the information, explanation, and treatment provided take local illness concepts and social values into account? Do the patients feel welcome and cared for? Do the patients trust in the competence and personality of the health care providers?

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(Table is used courtesy of its developers Obrist, Iteba, Lengeler …*et al.,* 2007. Also see AppendixXVV)

4.8 Access to Health Care in Contexts of Livelihood Insecurity: A Framework for Analysis and Action

Brigit Obrist, Nelly Iteba, Christian Lengeler et al., (2007) developed the *Access to Health Care in Contexts of Livelihood Insecurity: A Framework for Analysis and Action*.

In this framework, whatever degree of access was reached along the five (see table below) dimensions depended on the interplay between

(i) the health care services and the broader policies, institutions, organizations, and processes that govern the services, and

(ii) the livelihood assets people could mobilize in particular vulnerability contexts. However, improved access and health care utilization had to be combined with high quality of care to reach positive outcomes (see water filter below). The outcomes could then be measured in terms of health status (as evaluated by patients or by experts), patient satisfaction, and equity. (Also see Obrist five dimensions of access to health care services table above

4.9 A Preview on Frameworks and Models of Quality Health Care from Kenya

4.8.1 'National Policy Seminar Kenya' 2013

In June 2013 a seminar brought together key Kenyan stakeholders and health care quality leaders from other countries to share experiences and ideas on successful models for leading and supporting improvement of health care at all levels of the health system. This was referred to as the 'National Policy Seminar Kenya' (Technical report, 2013).

The seminar raised and tried to focus on four questions; upon which this author wrote this book, albeit attempting to answer them in a very small way.

These were:

- How did the improvement effort(s) you have experienced start? Who championed it? How was commitment sustained? How were improvement priorities set? What infrastructure was created to support improvement? How did it work?
- What improvement approaches were used? How and why did you choose? How did they work? How did you resolve the balance between minimal standards and best practices? How did you review progress? How did you communicate and coordinate? If you were to undergo this experience(s) again – what was important that you would want to see repeated?
- What is the role of accreditation? What are the next steps and directions for accreditation in Kenya?
- What would you advise the Ministry of Health (MOH) of Kenya related to national improvement strategy?

Participants recognized that in the health care improvement work done so far in Kenya, while different improvement methods were used, the underlying principles in each approach were similar, typically included standards and the plan-do-study-act cycle.

The forum agreed that the MOH should set priority areas of focus because to try to improve everything at once would overburden the system. Key to these priorities was to empower providers to make the changes that need to be made and foster shared learning (Technical report, 2013).

4.8.2 Kenya Quality Model for Health (KQMH) - a snap shot

The Kenya Quality Model for Health (KQMH) was aimed to develop and implement a robust and operational policy for quality in health care that could positively impact health outcomes for all Kenyans. In the seminar above (Technical report, 2013) it was noted that as far as the KQMH, the Ministry of Health had priority objectives that identified the main quality gaps of concern, but priorities for quality improvement still needed to be determined.

KQMH is a quality system based on the main models of quality systems established and used all over the world. Among others, it combined the standard models in terms of quality management.

These included: (i) Donabedian's structure, process - outcome model; (ii) the Deming Circle or Plan, Do, Check (Study) Act (PDCA/PDSA) cycle; (iii) the Japanese 5S and; (iv)Continuous Quality Improvement (CQI). Furthermore, the KQMH integrated

evidence-based medicine with total quality management and patient partnership (Please see Appendix VI). Apart from this approach in KQMH various Quality Improvement methods are available today.

Quality improvement uses data to monitor outcomes of care processes and use improvement methods to design and test changes to continuously improve quality and safety of health care systems.

Another common QI format uses the acronym FOCUS-PDSA:

- Find a process to improve.
- Organize an effort to work on improvement.
- Clarify current knowledge of the process.
- Understand process variation and performance capability.
- Select changes aimed at performance improvement.
- Plan the change; analyze current data and predict the results.
- Do it; execute the plan.
- Study (analyze) the new data and check the results.
- Act; take action to sustain the gains.

The KQMH implementation guidelines also embraced the use of diverse quality improvement approaches and methodologies drawn from the best practices and are designed and customized to address the needs of the Kenyan health system on current draft laws. The stake-holders seminar in June, 2013 recommended that the MOH needs to define tools that can operationalize the KQMH and provide direction to all stakeholders (Technical Report, 2013). This model will be discussed further in the next chapter.



Pic: Having a local perspective of models and frameworks of health systems through a worldview lens was important. (Courtesy of the photographer)



Pic: *Chama cha Wazee* male champions at the community health level in the Meteitei region of Nandi County, Kenya (Picture courtesy of Leah Ng'eno)

4. 8.3Kenya Health Policy Framework

Kenya's long-term health sector development is guided by the *Kenya Health Policy*. Within the health sector, the *Kenya Health Policy Framework* was the basis for the health development agenda in Kenya since 1994. The framework emphasized "quality health care that was acceptable, affordable and accessible to all."

The implementation of this framework was divided into two five-year strategic plans: the National Health Sector Strategic Plan 1 (MOH 1999) and the National Health Sector Strategic Plan II. *Kenya Health Policy 2014–2030* (*KHP*), aims to "attain the highest possible health standards in a manner responsive to the population needs"

In1994 the government published the first Kenya Health Policy Framework Paper (1994- 2010), which envisioned providing "quality health care that is acceptable, affordable, and accessible to all" in Kenya by 2010. The revised Kenya Health Policy, 2014 – 2030 gave directions to ensure significant improvement in overall status health in Kenya in line with the country's long term development agenda.

To guide attainment of the long term Health goals sought by the Country Vision 2030, the Constitution of Kenya 2010 and global commitments. The policy framework has, as an overarching goal, 'attaining the highest possible health standards in a manner responsive to the population needs'.

The policy will aim to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. The target of the policy was to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of the following targets.

Policy Directions to guide the attainment of the Health goal and strategic directions were defined in terms of six policy objectives (relating to Health and Related services), and seven policy orientations (relating to investments needed) (WHO, 2013). (See Appendix XVII)

The Health Services objective for the Kenya Health Policy is to: attain universal coverage with critical services that positively contribute to the realization of the overall policy goal. Six policy objectives, therefore, are defined, which address the current situation – each with specific strategies for focus to enable attaining of the policy objective:

1. Eliminate communicable conditions: aims to achieve by forcing down the burden of communicable diseases, till they are not of major public health concern.

2. Halt, and reverse the rising burden of non-communicable conditions: aims to achieve by ensuring clear strategies for implementation to address all the identified non communicable conditions in the country.

3. Reduce the burden of violence and injuries: aims to achieve by directly putting in place strategies that address each of the causes of injuries and violence at the time.

4. Provide essential health care: These shall be medical services that were affordable, equitable, accessible and responsive to client needs.

5. Minimize exposure to health risk factors: aims to achieve by strengthening the health promoting interventions, which address risk factors to health, plus facilitating use of products and services that lead to healthy behaviors in the population.

6. Strengthen collaboration with health related sectors: aims to achieve by adopting a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions.

7. Strengthen collaboration with health related sectors (public/private to other health related sectors)

The KHPF demonstrates the health sector's commitment, under government stewardship, to ensuring that the Country attains the highest possible standards of health, in a manner responsive to the needs of the population. It took into account the functional responsibilities between the two levels of government - county and national.

The policy aims to implement the priority health reforms envisaged in Vision 2030 with a view to ensure a healthy workforce capable of contributing towards the country's development agenda (MOH: Kenya Health Policy 2012-2030; also see Health Reform Resource Center-US).

With decentralization as the guiding strategy for managing the country's health care needs, the policy framework was implemented through two five-year plans. The first National Health Sector Strategic Plan [NHSSP-I] covered the period from 1999-2004

(KPSA, 2004) and the second covered the period from 2005-2010 (MOH, 2006). Under the framework the country's health system would be organized in a hierarchical pyramid.

The National Health Sector Strategic Plan (NHSSP II) underscores the importance of health system strengthening with major efforts directed at institutional strengthening, organizational development, improving the availability of human resources for health, health financing, service delivery and information, medical commodity availability, and improved donor coordination. There before, as NHSSP-I was being audited in September 2004 by an external team of independent consultants, their evaluation came up with the following observations:

> "...despite having well focused national health policies and reform agenda whose overriding strategies were focused on improving health care delivery services and systems through efficient and effective health management systems and reform, the overall implementation of NHSSP-I (1999-2004) did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio economic development as expected by the plan". This could have been attributed to a set of factors, most of which were inter-related, such as:
>
> - Absence of a legislative framework to support decentralisation;
> - Lack of well-articulated, prioritized and costed strategic plan;
> - Inadequate consultations amongst MOH staff themselves and other key stakeholders involved in the provision of health care services;
> - Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities;
> - Weak management systems;
> - Low personnel morale at all levels; and
> - Inadequate funding and low level of resource accountability.

As a result, the efforts made under NHSSP-I did not contribute towards an enhanced Kenyans' health status (Muga *et al.,* 2005). Rather, health indicators showed a downward trend. Infant and child mortality rates went up.

In this framework, Village dispensaries comprise the largest – and lowest – level of the pyramid. District health centres and provincial hospitals are fewer and higher on the pyramid, and the Kenyatta National Hospital in the capital city, Nairobi, as level six. The Ministry of Health was to be involved in policy (set policies, develops standards, and allocates resources for health care services) while the health services would be devolved to the county governments.

The government reports indicate that there were a total of 9905 health facilities in Kenya arranged alphabetically. The government oversaw 41% of health centres, NGOs run 15%, and the private sector operates 43%. The County governments would operate most public hospitals, health centres, and dispensaries, while the private sector operates nursing

homes and maternity facilities catering mainly to higher income clientele (Downlable PDF available).

As far as some governors were concerned all facilities within their territory fell under them, that was devolution to them. At some point of arm-twisting the national government was sort of forced to let go of more. For instance, the fate of Level 5 public hospitals (previously provincial general hospitals) apparently was not clearly spelt out in the Constitution 2010 (The Senate debate on 22nd July, 2014).

According to the Commission for Revenue Allocation (CAR), a level 5 hospital serving 1 million people cost over Ksh1.4b annually (excluding medicines, laboratory etc.). There was a tussle to delink county governments from controlling and handling level 5 budgets and allocations.

The county governments in some cases were known to hold on to conditional grants meant for these hospitals and only released them in small doses. One governor had even deposited some Ksh 300m part of the fund in a reserve account intending to use it to start another hospital somewhere within the county. Several stakeholders were of the opinion that as long as the fund needed to pass through the county coffers the intended purpose of developing these institutions might not be achieved.

On the other hand the central government was said to be holding on to functions, staff and programs it should have devolved. The same way counties were reluctant to take on some of the devolved roles especially those aligned to primary health care.

There was wrangling on both the clear and unclear roles in equal measure even though the constitution was somehow clear on where the two arms of government in Schedule 4. However, there was need for intergovernmental agreements frameworks to iron out the conflicts. Throwing the ball back and forth not taking responsibility and, not owning processes in the shared functions was not helping.

There were challenges inherent in this: perennial strikes by medical staff, funds shortage, corruption allegations, aging equipment and shortage of drugs among others. Procurement headaches were real with Integrated Financial Management Information System (IFMIS) failure to deliver towards smoothening the process as earlier promised.

As proposed by an amendment bill, Senate sought to give express rights for procurement of drugs and medical supplies through KEMSA on behalf of counties, though this was a bone of contention. Although *e*-government endeared itself in terms of governance by facilitating tracking therefore reducing corruption, the system could suffer serious downtimes.

In April 2017, IFMIS for some time stalled processing procurement, salaries and paying contractors. IFMIS (some civil servants called it '*if you miss*', after it failed them or paid in a haphazard manner) had not lived up to its promise as it were.

By early November 2017 the council of governers was considering legal redress to be allowed to do away with the IFMIS. They expressed frustrations about it being *switched off and on* by some people at the treasury. The Uasin Gishu governor speaking to the press alleged that IFMIS delayed their work rather than facilitated it.

Nevertheless some counties did better than others in terms of devolved health care e.g. Kisii, Makueni and possibly Bomet. In Makueni for example it health care had been made free in all public hospitals from 2013. Apparently it was more to do with management capabilities of persons vested with responsibilities to manage and not having any superior systems in place. Individuals, networks can fatigue but institutions do not.

Therefore it was better to fight to have strong institutions, systems, frameworks, models etc. Strengthening them included funding them deliberatively and affirmatively to enable them to do what they were mandated to do.

By the end of 5 years it was becoming clear that counties might not be in a position to handle health care, at least not the human resources for health (HRH). By the 117th day of the national nurses' strike (September 30th 2017), Tharaka Nthi Governor H.E Muthomi Njuki put it that way when he said 'It's apparent that counties have little capacity to run the health sector but they can support the national government through provisions of infrastructure and medicines…'

4.8.4 Organization of the Kenyan Health Service Delivery

So far ours has generally been a high demand and inadequate system capacity no matter how we try to organize it. Anyhow, the tiers of healthcare delivery system were organized into four tiers, namely community, primary care, county referral and national referral.

The previous tier system might or might not have changed much with the constitution (2010), but instead formed a platform upon which the devolved health services to the counties will be built. Community services would focus on creating appropriate demand for services, while primary care and referral services would focus on responding to this demand.

1. The community services comprises of all community based demand creation activities organized around the Comprehensive Community Strategy defined by the Health Sector;

2. The primary care services comprise all dispensaries, health centres and maternity homes of both public and private providers. Their capacity would be upgraded to ensure they can all provide appropriate demanded services;

3. The county referral services include hospitals operating in, and managed by a given county. This is made up of all the former level 4 and district hospitals in the county – government, and private. Together, all these hospitals in a given county form the County Referral System, with specific services shared amongst the existing County Referral facilities to form a virtual network of comprehensive services;

4. The national referral services includes the service units providing tertiary / highly specialized services including high level specialist medical care, laboratory support, blood product services, and research. The units include the former Provincial General Hospitals, and national level semi-autonomous agencies, and shall operate under a defined level of self-autonomy from the National Health Ministry, allowing for self-governance.

4.8.5 WHO Country Cooperation Strategic Agenda (2014-2019): Main Areas of Focus

Strategic Priority No.3: Improve health outcomes and embrace healthy lifestyles in a supportive and enabling risk mitigating environment through the course of life for improved quality of health and increased health adjusted life expectancy:

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH):-Support the national and county governments to build capacity to expand the access to quality evidence-informed interventions to improve maternal, newborn, child, adolescent, and reproductive health, whilst securing the health of older people through healthy behaviours

Health Promotion:-To support health and development, and prevent or reduce risk factors for health conditions using evidence based and ethical policies, strategies, recommendations, standards, guidelines at national and sub-national levels.

Social Determinants of Health (SDH): -To facilitate the development and implementation of policies and programmes to enhance health equity through strengthened inter-sectorial collaborations and partnerships for coordinated actions addressing Social Determinants of Health (SDH).

Strategic Priority No. 4: By 2019, the country has a responsive, client-centered, technologically driven and sustainable health system that is facilitating movement towards universal health coverage with defined quality health and related services, with protection from catastrophic health expenditures:

Organization of Service Delivery:-Support the National and County Governments in efforts to improve organization of devolved service delivery to improve physical, financial and socio-cultural access to health and related services, with a focus on organization of the health service package, the health system, health infrastructure, community health, facility management, emergency/referral, outreach, and supervision services.

Health Workforce:-Support National and County Governments' efforts to improve the production, productivity, motivation retention and distribution of the health workforce required to attain universal health coverage

Health Information:-Support National and County Governments' efforts to generate, analyze, disseminate and use of comprehensive health information from routine health statistics, vital statistics, surveys, census, and research

Essential Health Products and Technologies: Support the National and County Governments to improve access to essential medicines and health technologies; and to strengthen national and regional regulatory capacity.

Health Financing:-Facilitate the country in defining, applying and monitoring approaches to assure efficient and equitable use of health finances, in a manner that assures social protection

Health Leadership:-Support National and County Governments to build capacity for leading the health agenda, in line with attaining the policy and strategic

objectives for health Source (WHO, 2014). In this case, people who were smart and could lead from the front using models and frameworks.

Social protection is meant to cushion poor against disasters that can lead to impoverishment when shocks affect the ability of households to cope. The costs of seeking health care, caring for the sick can be one such a disaster. The shock may be sudden, cyclical, repeated or long term. The Kenya National Social Protection Policy of 2011 describes social protection as:

> Policies and actions, including legislative measures, that enhance the capacity of and opportunities for the poor and vulnerable to improve and sustain their lives, livelihoods, and welfare, that enable income-earners and their dependants to maintain a reasonable level of income through decent work, and that ensure access to affordable healthcare, social security, and social assistance.

Formal social protection also includes among others: National Hospital Insurance Fund, free maternity and free treatment for under-five's, cash transfer programs for vulnerable population, *Kazi Kwa Vijana initiative, Ajira digital program* for unemployed youth, Kenya Youth Dialogue Forum etc.In April 2018, the president launched Ksh 4.05b NHIF comprehensive cover for students in secondary schools. At Ksh 1350 per student per year for the 3 million students. However, there was the danger of duplication of those already covered.

This far and for the purpose of this book the focus has been the public health system sector, nevertheless the role of the private sector is so instrumental in access and provision. Roughly making up 50% of health facilities in Kenya albeit skewed in terms of distribution, opting for area which more urban, well connected infrastructure-wise, below is a review of the public private partnership strategy.

4.8.6 Public Private Partnership (PPP) Strategy

Kenya was spending about 5.6 to 7% of the GDP on health but recurrent expenditures had not increased both in absolute terms and as a proportion of total GOK spending and GDP. The Vision 2030 recognized role of private sector in improving the delivery of health care in partnership with the public sector. The private sector included both for-profit and not-for-profit entities, such faith-based organizations (FBOs) and non-governmental organizations (NGOs).

Out of the 9,905 health facilities in Kenya, 48% of these facilities are managed by central government/ county governments. Some 33 percent of these public facilities scored less than 50 per cent in terms of efficiency compared to only 1 per cent among their private counterparts (Quartz report, 2013).

Even though health care (and especially health facilities) was capital intensive, it was not right to assume that healthcare could be cured with more funding of the public health sector or could it? No amount of money can do that.

Source of public financing (including health) in Kenya was almost exclusively taxes (hence high tax burden) since the country did not have much in terms of natural resources. The US was a good example; even with more taxes towards healthcare, a large population could not access quality health care. Healthcare was everybody's business.

These among other factors showed that there was need for more private sector investment; increase its market share in health care as a sure way that funds would be

spent efficiently. The private sector also did not rely much on donor funding and taxes. Accessing competitive financing was crucial to private sector but was difficult to come. A private investor needed to service his liabilities and make a profit.

At least Ksh 100m was needed to invest in a fairly modest cottage hospital that generates a turnover of at least Ksh10m monthly in order to attract credit from financial institutions to further capital development. In order to do this one needed highly trained heath care staff, reliable suppliers and financial partners. The bottom line was how well they took care and treated their patients so that they might consider coming back or refer other clients to them.

Policy decisions were needed to ascertain the level of competition that could be entertained between the public and private or private to private. In 2017/18 Ksh 61b fiscal year health budget the government removed taxes on medical equipment for specialized care. This would in essence reduce the high cost of entry into the health care market. In 2013 USAID and General Electric (GE) committed USD10m as incentives to finance development of small to medium private health facilities.

From a global perspective there were organizations that covered more countries, these included The Clinton Health Access Initiative Inc ('CHAI'). This was a global health organization that had from 2002 helped more than11.8million people in 70 countries to access negotiated prices for HIV AIDS medicines, saving a lot of money.

The organization aimed to increase market dynamics for medicines, diagnostics, and access to lifesaving technologies therefore lowering prices for treatment. It also helped governments in strengthening integrated health systems and building capacity for high quality care and treatment.

This kind of networks and linkages could bring in a lot of value especially for informal sector (small and medium outfits). These are the kinds that were previously ignored in terms of opportunities and access to credit. These included clinics run by private doctors and private nurse practitioners, stand-alone diagnostic centres, physiotherapy and wellness centres, private ambulances, funeral homes etc. It could include moonlighting medical staff without stable employment who took chances at doing calls and as float staff.

In general the informal sector in Kenya tended to employ more Kenyans and contributed upto 30% or more towards the GDP. It had been observed that the formal sector was inadequate to do health care. They needed assistance in terms of technology transfer and innovation to be assured that their investment was of acceptable quality that translated to utilization. That way it was also possible to have a private health sector with a strong labour force, financing that could invite strategic investors.

During the 2 days Lake Region Economic Block health conference held in Kisii on March 27-28th 2017, participants underscored the role of the private sector in systematic investment that would drive health care in the counties. This was the case in developing countries. The conference called 'investing in health' brought together 13 counties surrounding Lake Victoria namely: Kisii Nyamira, Bomet, Busia, Kakamega, Migori, Homabay, Siaya, Kisumu, Trans Nzoia, Vihiga and Bungoma.

Inspite of these, the private investment in the sector was rife, with the gaps in the sector been seen as attractive avenues for social transformation. This is set to continue as evidenced by expansion of private hospital facilities to accommodate the growing needs.

Kenyans were estimated to be spending about Ksh 10b every year on medical tourism to India for cancer treatment alone based on 2017 figures.There was a need to improve local based care to try and capture this market. May be as a response to this there has been a rise in the number of procedurally oriented specialty hospitals and centres (e.g. orthopaedic, cardiac, dialysis, imaging, et cetera) owned by specialists who own shares or as sole investors.

Unfortunately they tended to channel well insured clients from public hospitals where some of them also practice to centres that they owned. Sometimes this resulted in increased rates of say cardiac surgeries, raising questions whether all these additional procedures were necessary in the first place.

The private sector covered a wide range of health care providers, such as doctors, nurses, midwives, clinical officers, and pharmacists. A public-private initiative brings together the state and non-state actors in health to foster on-going dialogue on key and emerging policy issues linked to PPPs in health. PPP – Health Kenya was committed to strengthening health delivery through full participation of the Private, Faith-based and Non-government health sectors to attain Kenya's health goals.

The Private Health sector Assessment Report (Barnes *et al.,* 2010) gave some startling facts as follows: That the size of the private health care market was Ksh 20.7 billion; That 2/3 of money spent in the private sector was on health services rendered in hospitals; That the private health sector owned and managed almost two-thirds of all Kenya's health facilities; The private sector was the largest employer of health care professionals in Kenya.

Come to think of it:

> A colleague shared that Kanu Street Nakuru town (or *K*-street by the residents) by mid-2015 had not less than 20 chemists/pharmacies (this stretch of about 1.5 Km was also known for other things like the infamous over 150 drinking joints according to National Anti-Narcotic and Drug abuse - NACADA boss). If we took that each chemist employed directly or indirectly about 10 people. These would be 200 people, although collaborative data on business directories listed 57 outlets within Nakuru Municipality (population of 307,990 by 2009 census). This translated to about 570 people on retail pharmacies alone, then these figures were convincing.

The caucus was formed by Ministry of Health (MOH), Health Non-Government Organizations-NGO network (HENNET), Supreme Council of Kenya Muslims (SUPKEM), Church Health association of Kenya (CHAK), Kenya Episcopal Conference, and The Health Sector Board of KEPSA etc. All participating organizations acknowledged and agreed that the primary purpose of health PPPs was to transform the health system to benefit Kenyans who do not have access to quality healthcare services and products.

Traditionally Kenya had excelled in business, leisure and bleisure tourism but it also intends to become the regional provider of choice for highly specialized health care, thus opening Kenya to 'health tourism'. It had started receiving about 4600 such visitors annually.

Medicaltourists were broadly defined as people who sought quality treatment abroad, or in neighbouring countries (cross-border transaction) where the cost was significantly lower, leaving them with enough money to tour the host country as part of their recuperation. Also see Barnes (2008) *Private Health Sector Assessment in Kenya World Bank* - free PDF. It suggested ways of better engaging the private health sector in treating illnesses among the poor and other vulnerable population.

Kenyans who were in a position to do so had traditionally gone to India and South Africa for further treatment but a significant number had to fund raise '*Harambee*' to enable them meet the cost of flying as treatment. A number of such gestures needed to be recognized and encouraged as seen below:

'In 40 minutes of being on air after highlighting the plight of a boy with a brain tumour, *Kameme FM* listeners gave hope and cash to CF, a form 3 student who had a brain tumour. In the first 40 minutes Kshs 2,800,350 donations was received. He would be proceeding to India for the surgery[42]. Jadudi who was diagnosed with cancer of the brain was able to raise over Ksh 6 Million equivalent of (60,000 USD) in 48 hours through a blog, which would enable him travel to India for the 4th brain surgery.

In yet another episode before 24hrs were over, Kenyans had raised over Ksh7.398milion (USD 74,000) for baby Jeremiah Charles Jr urgent kidney transplant in India, thanks to *Koinange Jeff Live*[43]. One Ndungu Nyoro, a pharmacist had effectively employed the use of social media to mobilize funds towards many needy patients to access medical care within Kenya and overseas. He won the OLX Soma Humanitarian Award in 2017.

There was the ever present danger of abuse and donor fatigue of such fund raising efforts. Cases where the cash are channelled directly to the individual patient's account should be discouraged. It would have been better if the kitty (e.g. for each media house) assembled for each needy case was re-channelled to a common kitty once the ceiling for each case was reached (and on the basis of merit/fact-check), the surplus preserved for the next needy patient. There was need to support this and other models of welfare system.

National as well as county government could supplement such efforts pegged on proportion of funds raised. Perhaps mount revolving funds, may be there were beneficiaries who could repay some or the funds back. Great fundraisers and mobilizers should be recognized and incorporated in government programs.

As can be seen a lot of our efforts and resources have gone to India and it is about time we reversed this trend. Kenyans spent an estimated USD120 million annually on medical treatment abroad, causing problems on loss of scarce foreign exchange. In 2011 India Medical Times heading read *With medical tourism picking up at a fast pace, the number of patients travelling from Kenya to India was expected to more than double to 50,000 during the current year, compared to the previous year as the cost of treatment in India is as low as a tenth of what is in Kenya.* In a followup, by 2017 an estimated Ksh 10b was used by Kenyans for cancer treatment in India alone, 10 members of parliament being among them.

[42]Njogu Njoroge (formerly Kameme FM anchor) on Fan page, 27th Jan, 2015 https://www.facebook.com/njoguwanjoroge?fref=nf

[43]Jeff Koinage live KTN 1st October 2015

"The real attraction to medical tourism is saving money on what normally are very costly procedures. The cost of surgery in India, kidney transplants, cancer treatments, among others, can be as low as just a tenth of what is in Kenya," Prof Anyang Nyongo, Minister of Medical Services, Kenya, said while addressing the 1st Indian Medical Tourism event, held in Nairobi on March 17-18, 2011[44] .

Fortunately, the government of India had partnered with Kenya to start a cancer hospital at KNH which would open its doors soon, The Hungarian government had partnered with Kenya to build another in Nyeri. This would ease the burden for those who used to travel to India for treatment.

India had several sophisticated procedures like bone marrow transplant, heart surgery, kidney and cancer treatment among others. This was partly because it was observed that India had enough medical equipment in low level hospitals which sometimes charged like mission hospitals in Kenya. In August 2017, Max Health Care (India) opened a branch in Kenya to offer multidisciplinary specialties in cancer, kidney etc. This was going to take care the many people who needed to travel to India for the same services. By half of the year 2017 about 117 people had travelled to India.

According to A & K Global Health Services which had a contract with NHIF to handle logistics for Kenyans traveling abroad for medical treatment, India had many specialists, offered diversity and holistic approach to care. Could it be possible for NHIF to meet 100% the cost of bone marrow transplant whether in and out of the country since it was reasonably cost effective with an almost 100% chance of cure.

But more important was getting these facilities locally. It was just unfortunate that at times this NHIF extended cover was abused by some who sought for clearance to go out over fairly easy health problems that could be sorted out locally. This could be perhaps be driven by cost, quality or sheer lack of confidence in our health system.

At Ksh 45b, Kabarak Teaching, Research & Referral Hospital would be the first private mission University hospital of its kind in the country. The ground breaking done in June 2017, the 250 bed hospital on a 247 acres of land targeted to have state of the art cancer, cardiology, stem cell regenerative medicine, treatment facilities. It would attract medical tourism from East and Central Africa at large.

The program partners included: General Electric (US), Sygec International (US), Eiffrage (France), EGMF (Belgium), CMB (Italy) among others included modernisation of 23 mission hospitals under Church Health Association of Kenya (CHAK) and training of health workers it was projected will open its doors in 2020.

Mwale Medical and Technology City in Butere sub County of Kakamega County in Western Kenya was perhaps the largest single private development in Kenya investing US$2b towards the metropolis. Commenced in 2014 on a 5000 acres of land would be completed in phases. It would house a 5000 bed referral hospital and medical school treating about 12000 patients daily. 4800 residential houses for doctors, nurses and other

[44] India Medical Times IMTD2011Africa. http://www.indiamedicaltimes.com/2011/03/26/50000-medical-tourists-from-kenya-expected-to-visit-india-in-2011/

staff, 1500 rooms golf resort, a Hampton's Shopping Mall, a 144 megawatts biopower gasification project (Details available @mwalemart.com on social media).

Every effort towards partnering with private sector can go a long way. For example in June 2017 Freedom from Fistula initiative and KNH received Ksh12m from Safaricom, Royal Media Services, Flying Doctors of Africa, that would see about 200 women benefit from free reconstructive surgery. A lot of these initiatives relied on goodwill of fundraisers and sponsors. Approximately 3000 women suffered from obstetrics fistula annually in the country.

According to Toby Tanser, CEO for *Shoe4Africa Foundation*, "it's true that about 98% of all requests for funding support result in a negative answer"[45]. The 2% positive response has transformed the lives of so many in sub-Saharan Africa. *Shoe4Africa* fundraised for the 1st dedicated public children's hospital in Eldoret. It's a 105 bed facility part of the Moi Teaching & Referral Hospital Complex, which opened in August 2015.

The term health tourism includes spa and gym, naturopathy, yoga, meditation and many other mental and physical exercises and treatments that are beneficial for health and rejuvenation. Health spas were intended to serve as curative centers as well as tourist attractions.

The government of Kenya has developed the Health Sector PPPs Strategy. The Strategy provides a number of investment opportunities in health service provision involving a private sector partner having management control of public hospital in order to get return on investment (ROI) at rate that does not hamper access to quality health care to the citizens.

Some of the PPPs - related investment opportunities are in telemedicine; referral or sharing of medical resources; local manufacture of generic drugs, adjusting products to meet unmet demand; creating new model for mobile; remote and home based health care; and creating new opportunities around rapid penetration of mobile phone technology (*Softkenya Health Sector in Kenya Investment*).

In essence, the country has the largest private health care segment in the East and Central Africa region. This promises significant potential for financial returns. The Kenyan pharmaceutical market is a lucrative option for many investors perhaps since there is some leeway in terms of refunds on medical claims as well as growing middle class population that was increasingly able to pay for better health services and pharmaceutical products. For years, drug companies have been the most profitable industry in the US, the prices are unregulated (Bodenheimer and Grumbach, 2012).

The pharmaceutical industry was a major stakeholder in health care and in a big way calls the shots. In the US between 2006 and 2008 the health industry spent more money on lobbying than any other sector of the economy, and the drug industry was the largest contributor/sponsor (Steinbrook, 2008). Looking at the pharmaceutical industry and the impact they have on politicians, Americans for Campaign Reform - ACR (2010) estimated that drug industry contributed US$167 million to federal candidates between 1990 and 2008.

[45] *The Standard* Wednesday 12th August 2015 pp 22, Moi Teaching & Referral Hospital supplement

We may not know for sure what impact these kind of relationships between industry and politicians has had on healthcare but suspicions were rife about a 'healthy relationship' between alcohol industry and for that matter illicit brews/drugs and politicians in Kenya. I feel a little cynical about special interest groups funding politicians - how do we know what the politicians intentions truly are if they are getting paid by these groups to move along policies that matter to them?

This could have had a significant impact on healthcare laws that would potentially benefit these groups. It's hard to trust the parliamentarians when a big money incentive is involved (see **An essay: Why were there no medicines in Kenyan hospitals if there was so much else to show off?** in Chapter 3).

The drug industry, equipment, medical insurance and non-pharmaceuticals industries were is notorious for inducing healthcare providers (mainly physicians) through sponsoring symposiums, trips, honoraria to those who can give a positive word and prescribe their products. Some (not all) make believe data is flaunted from funded research by the same manufacturers.

This obviously has a bearing on the quality of health care especially in a cash strapped economy as ours. The amounts are definitely colossal and it would be possible to imagine what those lobbying funds could do for actual patient care.

Pharmaceutical sales representatives regularly visit doctors' offices and use their techniques as example of how to promote new medical innovations. But in a sense it is terrifying when the salesperson acknowledges that "evidence is not remotely enough" as he/she convinces a doctor (some notoriously stubborn) to prescribe a drug to patients:

> '*That's why he stocked doctors' closets with free drug samples in person…Have you seen this study on our new drug? How about giving it a try?" As the rep had recognized, human interaction is the key force in overcoming resistance and speeding change'* Gawande Atul in *Slow Ideas*.

It is for this reason that users (care providers and patients) looking for credible, clear, concise, complete, unbiased, and patient friendly information online are advised steer towards websites with the least conflicts of interest (McClanahan, 2013).

Even in developed economies it's the same thing in a different context. This was what a subscriber shared concerning whether or not US should go single payer health insurance or not.

'I think it is POLITICS and Corporate Influence by those who would tend to lose their Profits and Power, if the US went to a Single Payer System, who object the loudest? I am trying to be tactful. It is NOT the American people, who object, it is the politicians, who already had the best benefits of almost any group'.

Other private outfits included: stand-alone preventative care (e.g. physiotherapy, nutritional, herbal based etc.) and diagnostic services (CT scans, Radiology). High end clinics (by e.g. The Aga Khan University Hospital, Africa Air Rescue-AAR, Nairobi Hospital, Evans Sunrise Hospital etc.) that target growing middle and upper-income

groups are especially profitable and provide high quality care that attracts patients as well as experienced staff.

A number of chain medical facilities; as well as stand-alone local private hospitals have upgraded their infrastructure and equipment. At a fraction of the cost abroad, many procedures could now be done locally. Fee-for-service was the predominant mode of provider payments in both private and public health insurance.

Medical expenditure = Prices of services x Quantity of services provided. Prices of medical services are determined by supply (sellers of services) and demand (buyers of services). Can quality also increase if the cost of provision increases? As demand for medical services especially among the employed (who happen to be insured) increases it increases medical expenditure. Other key factors in medical expenditure are growth/advances in medical technology, new ways to diagnose/treat; new medical devices; new diseases becoming prevalent etc.

According to Ginsburg (2008), in the US between 1992 and 2000 advances in technology related changes in medical practice accounted for average 60% increase in medical expenses, while aging population accounted for 2%. Changes in 3rd party payments (medical insurance) and administrative costs accounted for 10% respectively. Literature also suggested that a change in health insurance affecting large numbers of people was likely to influence the care delivered to all people and influence technological change and even provider productivity (Ginsburg, 2008). All the more reason why the National Health Assurance (amendment Bill 2015) might have proved quite beneficial to Kenyans if implemented as it was, but that was not to be.

As an old adage goes *The most expensive piece of medical equipment, as the saying goes, is a doctor's pen,* but at the same time another adage goes that *while journalists publish their mistakes doctors bury theirs*. Apart from cost in monetary terms, what they do or don't do are invaluable, a matter of life and death.

It seems this concept was introduced to some of people from a very early age. If I remember well, a certain nursery rhyme went like this (See Miss Polly below):

Interrogating the medical bill

Many Kenyans do not feel empowered enough to interrogate the hospital bill. Every day they know they were being credited but they dare not ask *lest it's too such*. A good number of them request for it upon discharge or demise of their loved one. Then they take off in a huff to start looking for funds from God know where.

It would be more prudent to ask to go through your bill on a day to day basis, scrutinize it when the memory is still fresh about consumables, procedures and orders that had been made, inquire from the regular staff the meanings of items in the bill. In one private hospital the surgical pack meant for those patients in the surgical wing while those medical side were charged a medical

pack. It was not unusual for the same patient to be charged both. While this error (whether deliberate or not) was obvious to the finance department they will wait for someone else to bring it up, what if they don't? Remember - everything adds up to the bill the patient pays.

Mind to know what packages exist. Some hospitals had a discount to those who book and pay for a delivery suite early in their pregnancy. Take advantage of such offers even if you have a comprehensive cover.

Patients have ended up making orders for items which in actual fact they were entitled as covered by the daily bed charges. Imagine failing to circle large meal in the menu only for you to end up sourcing for more at an extra expense. Asking the salons to do a complete pedicure/manicure when in fact this was not part of your common habits. You will be surprised that even some fellow patients might have some clue.
Then ask to sign off the bill. Take a photo scan of it and share with someone who might be helpful in future.
The same precaution applies even to the insured; it was good to spare something on your side of the insurance just in case several months down the line the amount remaining might not meet your next admission. Making a saving is always good practice even when you are a corporate client. It was a general observation that the billers took advantage of insured client since they were likely to be less keen (or cared less). In such circumstances a pair of slippers being costed at Ksh 1000 have been cited by members of public.

Mind to know how your bill was computed. In the unforeseen future your status can change. It's arrogant (or do we say ignorant) to just sign off your bill without an iota of scrutiny. As one person said 'don't be too ill to care to know what is happening to your bill, it is equally sick'.

At times a nagging question does wonders – by the way how much will I be charged for that? How necessary is it? Can we do without it? What would be the effect? For instance a series of other (not so necessary) tests. But have in mind that fees for the same procedure can vary greatly across providers and geographical areas and were unrelated to differences in practice costs as such. Question that too.

Please enjoy this little rhyme if you could.

Miss Polly & The Doll



Miss Polly had a dolly who was sick, sick; she called for the doctor to be quick, quick …. The doctor came with his bag and his hat, and he knocked at the door with a rhat tat tat. He looked at the dolly and shook his head. He said, 'Miss Polly put her straight to bed'. He wrote on a paper for a bill, 'I will be back in the morning with the bill'… [*Courtesy of Hoopla kidz YouTube*]. Never mind: Miss Polly was a pre-schooler, dolly was actually a doll. Online E.L actually responded thus 'So she called the doctor for a doll?, besides dolls do not get ill, they are neither alive or dead' J.G responded, WHAT EVER HAPPEND TO THE BILL? Miss Polly settings were different from Kenyan's. More likely drawn from a developed country.

Though only about 24% of personal medical expenses accrued to them, physicians in US were said to be the revenue generators, and controlled a large portion of health care industry, it was estimated that physicians' decisions contributed to 80% of total health care expenditures. They determined admission to the hospital, length of hospital stay, use of ancillary services, prescription of drugs, referrals to specialists, necessity for nonhospital care like rehabilitation or home care.

Sometimes they even felt compelled to accommodate patient's requests for interventions that they knew were unnecessary as was explained by Cassel and Guest (2012) in 'Helping Physicians and Patients Make Smart Decisions About Their Care' a *Choose Wisely* initiative by American Medical Association (AMA).

When physicians were ordering for tests, imaging, surgeries, referrals etc. as to whether these are always necessary or are just but a way of bringing in more business, that's another thing. A sizeable number of these hospitals are co-owned by healthcare providers,

therefore there is a tendency to over order by becoming innovative and aggressive in finding ways to increase revenues from patient care (Gawande, 2009). It is not unusual to find that financial considerations drive the decisions doctors made for patients—the tests they ordered, the doctors and hospitals they recommended.

For a country like Kenya it would be unfair for a doctor to be remarkably oblivious to the financial implications of their decisions. Whenever they see their patients, make their recommendations, send out the bills, it is important that they have the interest of the patient (including the financial) at heart. It is would be good for this country to set up to meet the needs of the patient, first and foremost, and not to maximize revenue (see **Inflation** below).

4.8.7 Relooking this Public Private partnership

Since the health system funding in Kenya was unlikely to change drastically in the near future, it would be good to suggest and implement of several, diverse viable options. The least of which would be to encourage companies to have a 'give back policy' by actively investing in social amenities for communities.

The other was to innovatively see how they could factor in a health component in their commercial pursuits. For example a partnership between *Airtel Kenya®, MicroEnsure® & Pan African Life Insurance®* targeting 12.6 million people, the move would see to it that Airtel subscribers who used Kshs 250 per month get free medical insurance from July 25th 2015, for example Outpatient care would be Kshs 10,000. A move in the right direction, or is it too good to be true? But that was what they promised in the official launch.

Established insurance outfits like Britam® in collaboration with *Safaricom®* and *Changamka® microfinance* started a revolutionary low cost medical cover Linda Jamii up to Kshs 290,000 per family per annum for only Kshs 12,000 payable via mobile pay. Others have heeded to this gesture and come down to the rescue of low income earners to provide some affordable policies to enable more Kenyans access quality health care. Other low cost insurance incentive provided through International Labour Organization in conjunction with *CIC/NHIF/MFI, UAP/Equity Bank*, *Jamii Bora Micro finance* among others.

Linda Mama under NHIF (free maternity scheme) was experiencing problems in its initial stages in terms of it not being comprehensive enough to cover women who were delivering in some of the public hospitals. This had resulted in some card bearers being detained for owing hospital bill. Such Facebook reports were coming as late as January 2018.

In March 2018, NHIF rolled out a *Platinum cover.* Its attractive benefits included a cover of upto Ksh10m for outpatient, dental Ksh 25,000 etc. It targetted corporates among others. A caucus of over 300 former members of parliament were among the early adopters of the scheme, the minimum premium each would be paying ranged from Ksh 328,000 per annum.

Inflation

I think it was unethical for a hospital to charge a patient who was paying out-of-pocket the same rate as patients who have insurances. It is well-known fact by some that prices were sometimes inflated in order to get some small percentage reimbursed by insurance companies. It was alleged that the huge cost covers the people that don't pay.

Out-of-pocket payers should not have to bear the brunt of this poor practice. And frequently out- of-pocket payers do not have money for insurance in the first place and certainly cannot afford a Ksh1000 ($10) for a bottle of normal saline!

I know very conscientious staff who are careful about the supplies they use since they know the patient will be charged. But at the end of the day (or shift!) they are just trying to provide the best care possible to their patients and don't have the needed information/mandate/time to worry about inflated supply costs…

There are no incentives to find a cheaper option for the vast majority of bedside end users or patients, 'some items cost a tenth at the pharmacy across the street, and we know it, but we are not to send the patient there, or can we?'

Many providers can obtain some supplies at less than average wholesale price but charge full retail price to the client, making a kill.

'Subsidies and free samples are meant for the needy but end up being sold or dished to undeserving people, friends and acquaintances, many of whom could even afford to pay anyway'

'I suppose there are answers, but not popular ones and nothing that will feel right with many commercially minded providers'.

Why is it so hard to pass on the benefits? May be this could be it - 'It was discouraging that nursing care was rated as an expense instead of pricing each activity in terms of people's time and effort, so why should I care?'

[Shared by several primary care providers]



Pic: In many parts of rural Kenya access to health care services often hampered by poor rood network and ravages of weather

[Courtesy of anonymous photographer]



Pic: Better days or rather, a typical scenario of constrained resources is that of stock-out in terms of medicines (Photo courtesy of Marylyn Mutenyo)

[**P.S**. *It was reported in the media that for almost a year public health facilities within Nairobi County had not been receiving medicines due to an outstanding debt of Ksh 285m (*Checkpoint KTN Dec. 10, 2017)].

Safaricom under the *Kenya @50* project had helped to refurbish some hospital wards. In this particular hospital of the 800 inpatients, only 10% were capable of paying their bills, leaving the hospital to care other patients at its own cost. Raising the question, how much should be spent on those who are medically indigent e.g. some mentally sick, street families, and how should their care be provided?

The National Insurance Fund (Amendment) Bill, 2015 before 11th parliament -The Senate Standing Committee on Health in July 2015, was an attempt to hopefully bridge the chasm as to which groups benefit and which groups bear the cost. There will be consequences of this approach and Kenyans need to be put in the know to better understand the economic implications.

On 14th January, 2014, President Uhuru Kenyatta launched the *Civil Servants and Disciplined Services medical Insurance Scheme*. This will target about 900,000 people since in this new scheme the contributor's spouse(s) and five children up to the age of 25 were also covered. The ministry of Devolution, NHIF, Kenya Red Cross and AMREF Flying Doctors had partnered in the initiative. This was an important enhanced cover in addition to what was being offered by NHIF. It included other benefits such as 24- hour call service, pre hospital care, medical evacuations and hospital transfers. Also included treatment outside the country. Amref's *Maisha* Scheme sets aside resources (in 2014 Ksh15.7m out of Ksh 85.5m)to help them evacuate patients with poor financial backgrounds on humanitarian grounds. See **section 4.9.2** of this book on Universal Health Cover.

An advert on health insurance and hospitals went like this:

You will be able to explore one or more of these providers... and get treatment from hospitals such as…



[Source: Kenya Best Expat Insurance Deals: http://ke.bestexpatinsurancedeals.com/?src=gdn]

It is important at this point to recognize the work of *Safari Doctors*[46]. This was a non-governmental organization supplementing government efforts on the need for providing affordable and accessible health care in the Lamu archipelago. Pandanguo hospital which used to serve isolated villages like Kiangwe next to Boni forest, Lamu County had been run down by Alsahbaab in 2014.



Photograph: The Basubadispensary in Lamu county stands desolate due to insecurity, some flooding was also evident from the picture.

[Courtesy of *The Star*]

[46] Feature Daily Nation, Jan 3, 2017 taking affordable healthcare where few dare go by Elizabeth Merab

The villages of Boni forest include: Mangai, Basuba, Mararani, Milimani, and Pandanguo. Essential services had been cut off by insecurity despite the presence of KDF soldiers for the last 2 years. The lack of healthcare service had become a distant memory. Health centres and dispensaries in the villages have been shut for over 2 years now, leaving residents at the mercy of traditional herbalists.

An attack on Pandanguo and Mukoe Health Center took place on July 2017. It had been deserted and just like several other abandoned institutions that nolonger functioned some had been turned into army camps. The Anti-Boni Terror Strategy that had lasted 2 years then had complicated the lives of residents and health care providers as well. This grossly affected healthcare. There was no best way 'strategy as it were' to do anything in the given circumstances. Time and again there were considerations stopping short of 'bombing the whole place'. As a result it had forced the government to pay hefty hardship allowance to keep some there.

It cost the Safari Doctors approximately Ksh 400,000 per month (US$ 4000) attending about 1000 patients for a full circuit to reach all the six villages in the Lamu island by road and water[47]. Planning for mobile clinics included ensuring medical team sailing team, medicines and meals. The founder of *Safari Doctors*, Ms Umra Omar was nominated in 2016 for top CNN heroes' finalist for her role. With discovery of oil and gas in the region whose drilling was expected to begin in late 2017, there might be some hope for the residents.

4.9 Supplier-induced Demand Model

Any public policies that affect the financing and delivery of health care services must consider physician's responses to those policies. He in an ideal relationship, is the perfect agent as well as the supplier of services for the patient legally and for decision making (medical needs, ability to pay, and preferences etc.). Not only are physicians supposed to act as agents for patients, but they are also suppliers of medical services; thus, if their income depends on the quantity of services supplied, *supplier-induced demand (s.i.d)* theory says that physicians will prescribe more quantity of services to raise their incomes (Feldstein, 2011).

That is why the physician according *supplier-induced demand model* must choose between the additional income received from unnecessary services and the psychological cost of knowing that these additional services are not really necessary. At times the patient themselves knowingly or unknowingly made the temptation greater As long as the patients deemed a treatment to be valuable (more so than the costs to the patient), the physician prescribed it (if this wasn't so great for the insurer!).

At some point (*hopefully* -emphasis mine) he must trade-off between additional revenue and the dissatisfaction that it's not worth it (Feldstein, 2011; p40). There will be those who induce demand only to achieve a given level of income (target). I believe there could be extremes either way.

However, because physicians possess a wealth of information unknown to the patient, supplier induced demand theory states that physicians will provide patients with "misinformation", "artificially" increasing patient demand for services that in-turn the physician can provide (increasing their income!).

Thus, the physician now becomes an "imperfect agent" The physician can always rationalize the patient's demand for increased quantity of services; however, there comes a point when a physician has to decide between additional income vs. knowing that those increased quantity of services may not really be necessary.

The fluid question still remains: in whose best interest does the physician act? What incentives are available (if at all) to keep costs low from monitoring, to profiling service providers, to limiting services? But then for the few Kenyans who happened to be well insured and could afford to choose how they interacted with the health system, would they generally opt for the lowest-cost option (to them) that met their needs?

Would they be interested in cost saving? If they have to pay to visit their doctor, then they are more likely to go to the specialist, to the high end clinic at a much higher cost to the health system. This in a way encouraged supplier induced demand.

In a resource constrained *unregulated* health care system that Kenya apparently was does have a big impact in terms of access and cost effectiveness of health care service provision. Kenya's increasingly health care costs left it in position 120 out of 144 economies that were ranked in terms of access to medical services particularly in view of its transition towards middle-income status (Global Competitiveness Report, 2014/2015).

According to Sarah Dods (2014), there was need to encourage better utilisation of lower cost parts of the health-care system that met patients' needs by all sectors of the population. But then we needed some kind of forecasting. Tools/models that could predict who, when and why patients arrive at clinics, hospitals etc. We needed to overcome the barriers that kept people in hospital after they were clinically ready to go home (discharge-ins). Other times patients may be discharged too early so may be unwilling to leave hospital, thus remain discharge-ins. Much as the care provider's income depended on the quantity of services supplied, we would rather find ways to deliver high-quality care with good patient outcomes at an affordable cost to the country.

4.9.1 Price check

Price is an important consideration to accessing health care since cost is obviously a major issue. Since the majority of Kenyans are self-funding and have limited resources it makes sense to use these monies for the most important treatment-associated costs. It is very important to identify and prioritize which resources address healthcare needs cost effectively and to consider alternative approaches.

Even for those people who were able to access private health care there was a bad side to it like the overuse of some services. Some practitioners shared how a routine visit to their outfit meant an adult client would have a 12 lead electrocardiogram (EKG), Cardiac enzyme/lipid profile and a series of other (not so necessary) tests. Unfortunately for some public hospitals (as well as some private hospitals) in Kenya, the items billed were so generalized that rarely did they capture the individual items costed (for reasons best known to them) so might end up overcharging or undercharging the client. These were hard to believe, how could this have happened?

A fairly common abuse was through passive reimbursement of the bills submitted by providers without checking whether the services were given, given as needed or not needed; or without negotiating the reimbursement rates. Anecdotal evidence revealed that some bills might capture dubious administrative costs or even an item on capital

improvements going on in the facility that they wish to raise funds.

This was compounded by more than generous rules of reimbursement, off course that could mean anything from writing open-ended rules of the game themselves, to coming up with bountiful formulas as well making payments without asking too many questions, to guaranteeing payments et cetera. In this relationship, there was an ever present danger that one side or the other could refuse to sign depending on when and who had an upper hand.

Reimbursement ought to be based on core measures e.g. rates of: readmission, pressure sores, bed occupancy, hospital acquired infections, customer satisfaction feedback etc. But generally core measures are basically a standard of care the hospital must meet to receive reimbursement, with the aim of improving care and reduce costs.

To the hospital this creates a challenge in that it has to be compliant with best practices. It was supposed to sow value into the consumer before it could reap the benefits. To the consumer it was wonderful thing but in the end it was better for everyone when we encourage better patient outcomes. These criterion for reimbursement were by large not a consideration in Kenya as yet.

In general, open marketplace exchange dictated that the price, quantity and quality of services delivered, and the how's of negotiation and incentives contributed to improved performance.

It then becomes interesting how (why?) naturally Kenyans strategically and actively bargain for high quality goods and services at lower prices but the same Kenyans would be willing to pay for a price, quality, efficiency and quantity of health care that was less than they deserve. Or opt to do without it altogether when they could not afford. But to do this and hold care providers account, they needed to have a lot of information at hand. Considerable information is required for users and payers to judge whether variations in cost were justifiable or not, and then to use this information to inform purchasing decisions.

The payers who included insurance companies must lead the way through performance or results-based payments, paying relatively low prices for high-cost but low-priority services Guarantees a minimum volume of services to be purchased; alternatively, a maximum volume may be set in order to limit total cost.

Introduces co-payments for patients who by-pass primary care, by self-referring to hospitals or specialists, use reference pricing or information on cost-effectiveness of medicines and reward those who do better for less (not with less) and making public such information(WHO, UHC virtual campus available https//who.campusvirtualsp.org).

As strategic way to try and improve both the quality and efficiency of health services, in the USA since 2009, for instance, Medicare stopped paying for medical complications which were clearly due to poor clinical practice, such as pressure ulcers and infections associated with catheter usage.

Few Kenyans have the guts or knowledge to question the bills. May be a few paying for health care out of pocket the so called 'credit risks' do, rarely do the insured clients bother 'after all they will not be paying out of-pocket "the insurance will cover it"' they say, they just sign the bill and check out.

The public have little incentive to compare prices among different providers (See **Shot and left for dead** in Chapter 2 and **18 hours ambulance ordeal** Chapter 4). Health care providers are also likely to increase fees more easily if a third party was available to foot the bill thus raising the fundamental question; does insurance make health more affordable, does it cut costs in the long run?

If a patient is well insured and the cost of care causes no immediate fiscal pain, the patient will use more services (some unnecessary) than someone who must pay for it out of pocket.What prevents providers from charging "higher-income" patients more fees?

Fees for the same procedure varied greatly across providers and geographical areas and were unrelated to differences in practice costs as such. Perhaps it's more likely a specialty and practice location matter. Providers who performed more services (e.g. surgery, tests etc.) were handsomely rewarded more than those who just did office consultations (patient evaluation, counselling etc.).

In a competitive market (supply and demand) the price of a service will reflect the cost of producing that service e.g. consumables, salaries, indemnity, rent (as well as the invaluable time, skill, intensity, effort and stress being factors) and that should be the premise. How do we adjust for the qualification/quality of the service provider (or should it the quality of the service provided pay for performance?), what is the coefficient?

How long after training does the specialist break even in terms of rate of returns relative to investment in the education he received? Should it continue to rise with experience or discounted? What if the fees rise exceeds economy-wide inflation?

Should providers attempt to collect 100 percent plus of their charges from those who have previously negotiated a discount? What if the patient is not empowered to know he can negotiate? Should the client continue to pay more just because he has been asked to? Can he seek justification at what point is he likely to get reprieve – as the service is being billed or after the bill is constituted?

If a health insurance company can negotiate a discount are rarely denied, would it be fair that cash paying patient still in debt even after clearing 80 percent of the bill, some being asked to provide a collateral surety to be allowed to go home. Most companies receive some form of discount on charges (rarely does a company/insurance have to pay 100% of charges). In resource constrained settings like ours the private health sector can make a difference by leading with a conscience.

In a normal market situation, rising fees would indicate demand was increasing faster than supply, and hence the need for corrective action (raising the fee), is this always the case for healthcare provider fee in our case? Lowering fee would be a more profitable strategy than rising it if the gain in revenue from increased client volume more than offsets the loss in revenue from decreased fees (Feldstein, 2011; pp131).

It would be possible to approximate the cost of performing a service as an approach is not something that would be welcome across the board. It I feel it would be too much effort that would not be sustainable in the long run. The survey (subjective data) on incomes may not be easy to access from providers. In any case the incomes might be so skewed to make sense of them using descriptive statistics (average, mode median).

Nevertheless in resource limited settings like ours it is not difficult to see who the winners

and losers are. Those missing out were at least 70 to 90% of the population, a conservative figure (based on 10% of population have health insurance. Absolute poverty levels are somewhere at 46%).

Aren't these practices alienating more Kenyans in terms of access, efficiency and equitability of health care? It might mean that Kenyans are not getting the best quality services, or the most financial protection for patients, given available funds. Resources used in a way which does not contribute to such progress are effectively being wasted, and are hence a source of inefficiency.

Only the well to do can access a certain level of service on a fee-for-service/ or out-of-pocket basis (albeit pre-paid fixed cost packages). Since the well to do are only a small portion of population then they have to pay exorbitantly to maintain the practices. Charge as much the market will bear, have the patient return more often, perform more tests etc.

Would a policy help to recoup something from these private outfits for the benefit of the less fortunate, would this drive up costs? Would we asking our practitioners to forego such significant revenue if we thought of it in terms of the country's economy and the people? It's the people that matter, the people of Kenya (See **Inflation** above).

For those with more than one cover, there was a danger of double billing for the similar goods and services. Undisclosed sources indicated that upon scrutiny, diverse keen observers were on different occasions able to identify extra items in the bill that were never used in some hospitals.

Why would they want to keep costs low if they're going to get paid for everything, right? Some even making claims and getting paid "retrospectively". Naturally, this could get out-of-control. These together with false claims were among concerns that faced NHIF in 2012-2013 scandals.

Even the common man had become cheeky. It was common knowledge that some uninsured patients somehow acquired 'an NHIF name' in hospital. Staff in a children's ward in one mission hospital said this was a 'normal' happening, almost expected. Such that the minor when called just looked at you as it took them sometime to get used to being called by the new 'NHIF name' which they discarded upon discharge. Until an opportune moment of *saidieko ile kadi yako ya hospitali* (everyday dialect from Swahili please let me utilize your medical insurance card).

Showcasing concern

"It's insane to pay Ksh 300, 000 to give birth yet it's a natural process. Labour should not leave you in debt," said Dr. O. K a 29-year-old general practitioner, a Certified Public Accountant (CPA-K from Strathmore University also pursuing a Master's degree in health economics. He was the proprietor of Ruai Family Hospital. A three-storey facility in Ruai Township, in the outskirts of Nairobi.

He was one of the youngest doctors in Kenya at the time to own and run a full-fledged medical facility in 2011. It had 32 beds, 12 permanent employees and hired top doctors on need basis. His story appeared in the news as he showcased for Youth Enterprise Fund in 2016, which had helped finance in part this undertaking. On average, we serve 60 patients every day and we are listed with all major insurance companies in Kenya including NHIF," Patients can access some of the lowest possible cost to each service.

A fair question would be, who do such 'malpractices' benefit? Is it the client really? Cost cutting for many entrepreneurs in healthcare was a question of whether the patient could

afford and not a necessary principle. In some instances the economic benefits may not be passed on to the client.

A good question at this juncture would be - do all public hospitals have a standardized charge sheet? Rarely were the charge sheets authenticated nor were they folioed for audit tracking. *Prices (of drugs among other consumables) were rising just because they can, not because they have to and nothing was holding them back, which meant companies can charge what they like* (Bach, 2015).

A database of health care prices does not yet exist in Kenya at the moment, but it could be created just as we do with other markets/stocks, why and why not? It was a matter of policy because it costs Kenyans (insured or not) a lot of money. The following statement was adopted from PriceCheck, a community-created guide to health costs, 'Buying health care is like going to the supermarket and finding all the price tags removed...

Even worse, bread might cost you Ksh50 and another shopper Ksh200, and you wouldn't know which until you get to the teller's counter. By collecting information from you and others like you, we can help change that…share what you paid'[48]. (See **The charge sheet** below):

The charge sheet

Duplication as well as inflation of items costed was not unusual …it is not unusual to have the same client billed for EKG and ECG … as if they were separate entities (Both mean electrocardiogram).

Ailments that would have been managed with simple drugs or remedies elsewhere are treated with second or even third line antimicrobials by many a private practitioner, with danger of developing drug resistance. Another thing is that we do not like very much cash paying clients mainly … because they are credit risks, even when they are not credit risks… why, because they question too much! (Shared covertly by a staff).

A classic example is the overuse of caesarean section (C/s) over natural vaginal delivery among women who were attended by private practitioners. While C/s can protect the health or save the life of mother or child, World Health Report (2010) indicated that in 2008 up to 6.2 million C/s performed were unnecessary costing 2.32 Billion USD, to the extent that WHO referred to it as a barrier to universal health coverage.

The Guardian reported that in Brazil, 8 C/s were done out of every 10 deliveries handled by private practitioners. Brazil's Minister for Health Arthur Chiuro called it 'an epidemic of C/s, a public health concern' Chioro denounced it, saying, "We cannot accept that caesareans be performed as a result of buying power or convenience". With so much profit at stake, medical guidelines and rules were unlikely to be deter this practice.

Locally, NHIF had paid Ksh 1b in the year 2016 for caesarean section, crossing the billion mark for the first time. In the first half of 2016 it paid Ksh 712m for 24,492 mothers. This represented a big cost burden of the procedure to insurers in general but it could mean several things including improved access to care but it could also indicate supplier induced demand (Reported in *Medicalkenya* on 18th April, 2017).

[48] State of Health, June 2014 Share Your Bill, Make Health Costs Transparent in California http://ww2.kqed.org/stateofhealth/2014/06/23/share-your-bill-make-health-costs-transparent-in-california/

Among the other challenges that faced the private health sector according to Burnes (2010) included: Lack of enforcement by the professional boards result in a highly unregulated private health sector; unqualified health professionals continue to practice privately in the country, despite some well publicized crackdowns.

Off course the last thing we want to admit is that in some facilities half trained, underpaid, *unfireable* people do medical work. Government workers were generally protected from reductions in pay and benefits and from being demoted or fired. We might happen to know some subordinate staff in Kenya do all sorts of skilled work whether sanctioned or not (see **Akichelesit dispensary** in Chapter One).

Responsibility for licensing of private health facilities was spread across too many regulatory bodies, leading to inefficiencies and gaps in monitoring quality of care; large quantities of substandard and counterfeit drugs circulated in Kenya, and government had *limited capacity to monitor and enforce quality standards*. About 6,000 facilities were in need of inspection and nearly two thirds of them needed to be shut down by the pharmacy and poisons board for operating without a license.

The Health Sector Assessment (HSA) 2010 report by Luoma *et al.,* (2010) did comprehensive review of the entire health system. They were able to reach the stakeholders through key informant interviews and also referred to studies and information about the trends and challenges facing the health sector. This report provided critical information about the strengths, weaknesses and made recommendations to improve the system.

The report provided valuable input to the review of the Kenya Health Policy Framework. They employed an approach that provided for a comprehensive assessment of key health systems functions, organized around six technical modules: governance; health financing; health service delivery; human resources (e.g. Government human resources information system (Ghris) part of Integrated Financial Management Systems (IFMIS); medical products management; and health information systems.

4.9.2 Relooking Universal Health Cover

[The bulk of these materials were gleaned from WHO online course covering the same content that this I participated in 2017 and my PhD Thesis in Medical Education Moi University entitled: *BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis: A Primer Model for Kenya*].

Universal health care by 2030 is one of the targets under the newly ratified sustainable development goals (SDGs). This target was likely to have different challenges for each country depending on its economic strength, relationships with donors, and the government's investment into the health sector.

Universal health coverage, according to SDG's is access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines. This also includes protection from financial risk in terms of health care.

Essential medicines

Access to medicines was part of the fundamental right to health. Provision of health services is incomplete without essential medicines. WHO (2002) defines essential medicines as:

"Those that satisfy the priority health care needs of the population. They are selected with due regard to disease prevalence, evidence on efficacy and safety, cost comparative effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and at a price the individual and the community can afford."

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized more than 30 years ago by the Alma-Ata Declaration1979 signatories, who noted that Health for All would contribute both to a better quality of life and also to global peace and security. The Alma Ata Declaration highlighted the importance of bringing healthcare and decision-making as close as possible to where people live and work; this could have been captured in the aspirations of Kenyans in the Constitution.

Not surprisingly, people also rated health one of their highest priorities, in most countries behind only economic concerns, such as unemployment, low wages and a high cost of living. The working 'walking' common Kenyan may be earning wages that did not entirely save them from starvation. It was also true that sometimes the high cost of some drugs made potential users to delay the beginning of treatment.

This could lead to some catastrophic situations e.g. the disease can evolve and provoke irreversible damage; chronic and disabling diseases might evolve that increase cost. As a result, health frequently becomes a political issue as governments try to meet peoples' expectations, but rising cost was.

In a related article in *TheConversation* March 6, 2014, Sarah Dods a research theme leader CSIRO wrote concerning Australia. She thought that the growth in rising health costs was driven by: an ageing population that was living longer but not in good health, increasing rates of chronic disease (such as diabetes, heart disease, cancer and asthma) that required long-term health management, and increasing expectations around medical advances and what the health system could treat. Patients with chronic diseases, for instance, are high users of our health-care system.

But unlike many other purchases in our lives, buying insurance is difficult, confusing, and provides little short-term gratification; so healthy young people will always tend to avoid it. The options become fewer so that unless consumers are required to purchase insurance or face a meaningful penalty they will do without it. A meaningful financial penalty could mean passing a legislation that any such penalty equals or exceeds the cost of buying insurance in the first place.

For many even well to do in Kenya it was only because their cover is employer related otherwise they would have no insurance at all. What about the problem of health coverage interrupted by a job loss or being an uninsured at some point. He/she is at risk of financial disruption with the spill over this could have on the family and community being another matter altogether. According to IOM, health insurance was a family matter: the effects being uninsured could have on the health, finances and general well-being of the family.

Timely access to health services – a mix of promotion, prevention, treatment and rehabilitation – is critical. This cannot be achieved, except for a small minority of the population, without a well-functioning health financing system. Medical insurance cover determines whether people can afford to use health services when they need them (WHO report, 2010 *Financing of Universal Health Coverage*).

More than half the world's population lacked any type of formal social protection, according to the International Labour Organization (ILO). Only 5–10% of people were covered in sub-Saharan Africa and southern Asia, while in middle-income countries, coverage rates range from 20% to 60%. But funds to finance health care can come from a variety of sources e.g. income and wage based taxes, broader-based value-added taxes or excise taxes on tobacco and alcohol, and/or insurance premiums.

Therefore a strong tax base was desirable for a stable sustainable health care system. However, tax revenues were unreliable sources of health finance, because of macroeconomic conditions such as poor growth, national debt, and inflation, which often affect health allocations. Decisions also need to be taken on pooling.

The tax bracket was a big issue for each country, lots of citizens escaped the net somehow, yet these were the funds the government hoped to use to fund security, healthcare and infrastructure among other competing demands. It was estimated that Kenya had 18 million entire workforce with 700,000 being in the public sector. The informal sector generated about 85% of the jobs but contributed less than 15% of GDP.

Income tax represented the sum of tax currently payable and deferred tax. Lots of taxable profits was perhaps not being remitted. The authorities were trying to rope in as many Kenyans to enter the tax bracket in order to raise more funds, but by 30th June 2017 end of the fiscal year 2016/17, only 2.4 million tax payers had filed their annual income tax returns.

There were serious penalties for noncompliance including paying Ksh1000 for every overdue date after the deadline but it was difficult to assess whether this had achieved compliance. Authoritative people and even political manifestos had proposed that if we could increase the tax bracket to 40% or more of the working people we as a country could do very well.

Questions

- Should these contributions be compulsory?
- Who should pay, how much and when?
- What should happen to people who could not afford to contribute financially?
- Should funds be kept as part of consolidated government revenues, or in one or more health insurance funds, be they social, private, community or micro funds?

Voluntary Private Insurers charge each person the average cost of providing health services multiplied by the average probability that a person would need care (plus a margin for administrative and operating costs).

In reality, however, individuals often have some idea whether they have a health problem or are at high risk, they will tend to buy voluntary cover. However, for younger and healthier people, being asked to contribute at the average cost will probably seem high relative to their perceived health needs, and they are more likely not to buy voluntary cover. Far more people with higher health risk voluntarily join a scheme which pools

revenues, than healthier individuals. As a result, premiums or financial contributions increase.

Pools should be large and cover a diverse mix of people, with a diverse set of health risks.

Many people in the country who try to buy a plan in the individual market reported that they were turned down, charged a higher price, or had a condition excluded from their plan because of their health. Therefore usually only healthy people could get policies, and only those with good incomes could afford the premiums. It is difficult to create a balanced risk pools that include both healthy and less healthy persons in individual insurance markets. The objective of pooling therefore is to maximize the redistributive capacity of available public revenues raised for health. This need for pools to be large and diverse,

Voluntary affiliation

Voluntary affiliation won't enable the creation of effective pools, because most relatively healthy individuals won't voluntarily contribute to a scheme. The mix of risks in such a pool is likely to be less diverse than on average across the entire population, in other words there will be more people with a higher health risk and with a lower health risk.

As a result, if the institution managing the scheme sets the premium or financial contribution based on the average need for care in the population, they will start to suffer a financial loss. In response, the financial contribution or premium will need to rise further.

Insurer respond, for example by raising premiums or through other measures such as excluding people with pre-existing health conditions, or simply making it difficult for people with existing health problems to join the scheme. A common approach is to investigate an individual's health risk, and then to charge them a premium or contribution amount which reflects their risk; another response is to exclude certain services from coverage.

As a result of such measures, the size of the insurance pool tends to shrink over time, resulting in what is often called the "death spiral" of voluntary health insurance. Sometimes it might improve the health benefits of members of the scheme but is bad for the health system as a whole from the perspective of towards universal health coverage, which aims to **meet the health needs of the entire population**.

Fig: UHC aims to meet the health needs of the entire population.

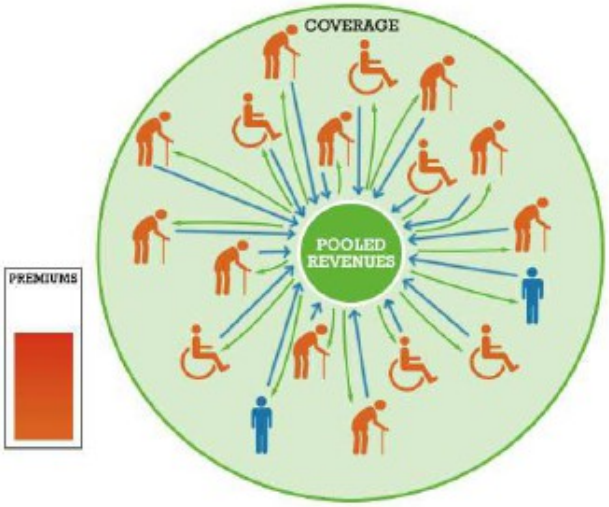
(Courtesy of HFP-UHC, WHO)



This problem is called **adverse selection** - individuals with higher health risks are more likely to join a scheme voluntarily, and those with lower health risks are less likely.

This explains why it is not possible for voluntary health insurance to play a significant or leading role in countries trying to move their health systems towards UHC.

Fig: Adverse selection. (Courtesy of HFP-UHC WHO)



Pools that protect the health needs of a small number of people are not viable in the long run. A few episodes of expensive illness will wipe them out. Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people.

All people of good will, doctors and nurses in the world cannot cure inequities in health care if the insurance system cannot. Inequities in service use and financial protection would widen between those inside and outside the voluntary scheme because a large population may be over relying on direct payments (OOP) at the time people need care. Financial penalty imposed on the ill (and often their carers) is often considered as lost income.

These include over-the-counter payments for medicines and fees for consultations and procedures. Even if people have some form of health insurance, they may need to contribute in the form of co-payments, co-insurance or deductibles. Almost all countries impose some form of direct payment, sometimes called cost sharing, although the poorer the country, the higher the proportion of total expenditure that is financed in this way.

The path to universal coverage, then, is relatively simple – at least on paper. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity.

Wealthy countries almost exclusively used ompulsory rather than voluntary arrangements as the main financing mechanism in the health sector. It is hence widely recognized that organizing the pooling of resources through **compulsory participation** is the best way to achieve the policy goals of universal health coverage. This would ensure that enough resources are available to effectively deliver the health services included in the UHC benefit package.

Contributions needed to be compulsory, otherwise the rich and healthy would opt out and there would be insufficient funding to cover the needs of the poor and sick (including the elderly, disabled, and those in full-time education). In most countries voluntary health insurance, whether managed in the private or public sector, contributes very little to overall health system funding. But as countries become wealthier, voluntary health insurance "evolves" or "graduates" to play a greater role.

Groups or the entire population as being automatically covered (e.g. all citizens, residents, or persons below a certain income level). In such cases, it is typical that funding would be from general government budget revenues. This type of "automatic" participation is demonstrated in the UK's NHS.

Or specific groups to contribute to a compulsory health insurance programme, under which the government may also provide subsidies for groups deemed unable to contribute (fully or partially). This type of **"compulsory contributory"** participation is demonstrated in Germany, the Netherlands and many other countries.

To make progress towards the goals of universal health coverage, compulsory participation works best. It is also possible for private companies to manage publicly-funded compulsory insurance, as is the case in Switzerland and the Netherlands.

Many low and middle-income countries are exploring voluntary schemes in the form of small-scale community-based health insurance (CBHI, often referred to as *mutuelles* in French, or also "health microinsurance").Unfortunately very few people enroll in CBHI, and they tend to raise very little revenue. And given the redistributional objective of pooling, small is NOT beautiful. The bigger the pool, the greater its redistributional capacity.

Fragmentation

Fragmentation – creates barriers which limit the potential for prepaid funds to be redistribute to where they are most needed. Fragmentation in pooling within health systems takes many forms. What to do depends on the specific nature of fragmentation in your country, as well as the consequences of this when we move this towards implementing UHC. Whatever reforms would be needed to reduce fragmentation or to mitigate its consequences.

Examples of fragmentation

Fragmentation takes many forms, such as:

D the existence of separate health insurance schemes for different population groups or of schemes that only cover some groups

D decentralized budgetary arrangements that do not allow for redistribution across territorial boundaries

D the existence of "vertical programs" that allocate resources directly to providers for specific health conditions such as HIV/AIDS or TB ...and many more.

Decentralization of health budgets to distinct sub-national units, or the establishment of a separate insurance scheme for civil servants, the potential to redistribute funds is constrained or limited. If prepaid funds are separated into multiple small fund pools, fragmentation (including geographical) increases, and the potential to redistribute funds is more limited.

Efforts to reduce fragmentation in pooling has the effect of increasing the redistributive capacity of the health system, and the potential to improve both service and financial coverage for the population. The challenge is how to move the fragmented health system towards a predominant reliance on public, compulsory revenue sources. Whilst a single and predominantly publicly-funded pool may be something that countries strive for, what they can actually implement is limited by fiscal constraints and political realities.

Thailand and Mexico health system had always been pro-rich but they have changed. Ghana and Rwanda had also managed to merge the many small pools by each taking action to reduce fragmentation in the way funds were pooled, and move towards predominant reliance on public funding.

Akin to "changing history" by fundamentally restructuring pooling arrangements, the starting point notwithstanding (some being outrageously biased and pro-rich), following the reforms each country had a larger and more diversified pooling arrangement, with more of their population affiliated to a compulsory financing mechanism. Such reforms in pooling have enabled greater equity in the distribution of health system resources across the population. We must think about how adequate revenues will be raised, pooled, and then used to purchase health services, to ensure that entitlements are actually delivered to the population. Other equally important factors are reducing fragmentation in pooling, developing effective purchasing mechanisms, as well as ensuring the trained staff, medicines and other supplies to ensure service availability, to ensure the entire health system achieves as much as possible. For instance purchasing mechanisms promote the delivery of priority services, with quality.

Where fragmentation already exists in a health system, it is not always easy to reduce, given that it often exists for historical, political, administrative and other reasons. For example, where separate schemes for different population groups exist, with varying levels of benefits provided, those with more to lose are likely to resist changes.

Actions are needed to reduce fragmentation for example merging different insurance schemes, or combining general budget revenues with payroll tax revenues into the same pool, have an important and positive effect in terms of increasing the redistributive capacity of available prepaid funds. There will often be political obstacles to completely eliminating fragmentation within a health system, but country experience shows that positive change is possible in terms of moving in this direction.

Diagnosing how pool fragmentation affects each country's health system, and the implications of this for policy objectives, is an important first step in the design of reforms to either address this problem directly or compensate for its consequences.

Case of Ghana

In Ghana by 2003, there were more than 250 small scale community-based health insurance funds called Mutual Health Organizations (MHOs) in the country - but these were very small (about 1000 persons covered per scheme) and affiliation was voluntary, leading to problems of adverse selection. National Health Insurance Act. Recognizing the problem of small pools, the Act essentially required that there could be only one MHO per district, effectively forcing smaller schemes to merge with each other into one district level scheme.

UHC is politics

According to Agnes Soucat, WHO's Director of Health Systems, Governance & Financing: *UHC was a political matter, for it to be given priority when it came to the public purse, to have it implemented would require pool funding through collective taxation. To sustain it from domestic funding was a priority. She observed that even though UHC appeared ambitious it was an achievable goal. But this was not going to be cheap as it would require significant public as well as private funding. Public financing would enable the poor and disadvantaged to get efficient health care services.* [Interview 13th Nov, 2017 by Devex in New York]. In his inauguration speech on 28th November 2017, President Uhuru Kenyatta pledged 100% Universal Health Care for all households in Kenya within the next 5 years. Makueni County had become the first to offer medical services free of charge in late 2017, as decreed by their governor. For the national UHC pilot counties set to begin mid-2018 would include: Machakos, Kisumu, Nyeri and Isiolo. However, many a governor resisted the piloting and insisting the roll-out be all inclusive.

Case of Rwanda

Rwanda's health system, was often referred to as Community Based Health Insurance. In any case what mattered was not the label but making participation compulsory and automatic. Rwanda was quite successful in enrolling the population. Rwanda had achieved a very high affiliation of the population of about 75%.

Some individuals voluntarily bought private health insurance. The government taxed these and transferred revenues into the national risk pool. A small part of the population contributed through a mandatory social-security type health insurance scheme.

A substantial share of funds was managed at district level to allow for "patient roaming" which meant that benefits could be easily transferred so that someone registered in one section could obtain services in another region. In effect, this created a single pool in each district. Finances also flow from the district pools to and from the national pool. Pooling is decentralized but integrated, with a common national risk pool that links all the district and sub-district pools, creating a single national pool.

As a result, Rwanda's CBHI achieves great redistributive capacity. Most people must contribute in order to be affiliated, and local government officials (district mayors) are held accountable for the enrolment rates of their population. As a result the system has transitioned from being voluntary to compulsory. There are two levels of premium that people pay, but these are set based on affordability criteria rather than financial risk. The poorest 25% of the population have their contribution fully paid for, or subsidized, by the government.

Those who have been assessed and are considered able to afford the contribution, make payments into the pool in their sub-district.

The key role of local government officials was one reason for this; others included the flow of subsidies and the linking of different pools. Rwanda had achieved a very high affiliation of the population of about 75%.

It was commendable that Rwanda’s has had unprecedented health sector performance. The country managed to reduce under five child mortality by over two-thirds, maternal mortality rate by more than half and HIV mortality by more than half between 2000 and 2015.

Decisions about benefit packages

Benefit package refers to the services and commodities paid for by the purchaser using prepaid funds. From a public policy perspective, the focus is on health services that are publicly funded. In addition to entitlements, the benefit package also defines the obligations of the covered population.

These are choices that face those deciding which health services to purchase (in the case of medical insurance policy holders).

In UHC these are publicly funded benefit packages. These may be fully subsidized i.e. publicly funded with no patient charge, or partially publicly funded (where this applies).

Benefit package specifies which health services are fully covered by public funds, and those which require individuals to make a co-payment. Also specifies which services and commodities that are excluded. In other words benefits are defined in terms of services that are specifically excluded, rather than specifically included.

Entitlements are those services and commodities either fully or partially paid for from pooled funds, for the covered population. Often defined entitlements to determine how funds should be used in the health care. Governments often define entitlements to determine how public funds should be used in the health sector. It is critical that service entitlements as defined in the benefit package can actually be delivered effectively within the fiscal constraints. A large mismatch between what is promised and what is delivered can seriously undermine a government's credibility.

Obligations

By clearly defining population entitlements through benefit package design, the population's obligations are also defined. For example, in order to access subsidized services, patients may first have to go to a primary health care doctor who will decide whether they need to go to a specialist - this is called gatekeeping. Other example include: certain patients may have to make a financial contribution or co-payment; patients have to wait until services are available and can only access them in a limited set of health facilities; only access generic medicines through the benefit package.

Rationing

All countries, whether rich or poor, limit service entitlements in the benefit package in one way or another. This is called *rationing*. By clearly defining which services are covered by the benefit package, and for whom, those services which are not covered are also clearly identified. Or rather rationing of service entitlement; explicit in terms of included or excluded services.

If the benefit package is out of balance with these other elements of health financing, coverage will be ineffective, and rationing will take place implicitly. Implicitly means the availability of services would depend on the level of resources to provide care; when and where. Implicit rationing can also occur e.g. through increased unofficial payments, or through poor quality care due to a lack of medicines.

All health systems ration patient access to health care. The private sector rations access by charging market prices, and as a result demand is driven by a person's ability and willingness to pay. Governments moving their health systems towards UHC seek to ration care on the basis of "need," for example by covering cost-effective treatments, and providing greater entitlements to people with lower-incomes.

A common situation in many countries is a mismatch between what is promised in terms of the benefit package, and what is delivered in practice. This mismatch often reflects that, due to the health budget constraint, there is not enough funding to deliver the health services promised to those who need them.

In the diagram below some of the possible policy responses and implications in such a situation. These are categorized as either explicit or implicit responses, and based on

responses which use either price or non-price mechanisms. The consequences of these responses from a UHC perspective are also highlighted.

The design of a benefit package

The design of a benefit package sends signals about government priorities in the health sector such as which services it considers most important. These messages are sent to both providers and users of services, and influences which services are provided, and how patients access the health system.

The benefit package plays an important role in improving:

D the efficient use of the health system

D the transparency of entitlements and obligations

D equity in service use, or utilization relative to need

D patient financial protection



Pic: This mother and her young children needed to be assured of accessing quality affordable health care whenever they need it.
(*Courtesy of Community Eye Health Update*)

'Sickness cannot be postponed, informing a patient to wait till a favourable date so that they can be treated tends to demoralize them and that is why it ideal for government to ensure that all facilities are equipped with machines that can ease the congestion' [L.K in *Health Watch* The Standard Nov 25th, 2017. L.K's wife was diagnosed with cancer of the cervix].

Think about it: Costly services- e.g. renal replacement therapy (RRT) is very expensive and detailed analysis shows that this service was not cost-effective relative to other interventions; this evidence supported the argument that limited public resources should be used to maximize health improvement more people in the population. Equity as well as Political pressure concerns usually triumph over these arguments in UHC (case of Thailand). The government obliged to find the money for RRT and other costly services. Offcourse at the expense of some other basic services. This illustrates the dilemmas, choices and tradeoffs that often have to be made on the path to UHC.

There are three principles which are often considered when prioritizing healthcare and deciding who will be covered. While they are explained here separately, in practice, they are considered simultaneously.



Figure: Principles considered when prioritizing healthcare (courtesy of HFP-UHC WHO)

Need

This principle supports health services being distributed in proportion to health needs, for example those in need of rescue from immediate pain and suffering, as well as those facing an immediate threat to life. This is represented in our framework as "utilization relative to need"; we also know that reducing financial barriers can be important to ensure utilization of services.

Health maximization

In this approach, health services are distributed in a way that achieves the maximum benefit in terms of overall population health. Hip replacement is an example of this as the money saved from the costly nursing care could be used to fund extra health care and further increase population health. Allocative efficiency analysis assesses which mix of services leads to the greatest health gain across a population.

Equity

This principle supports the distribution of health services in a way that reduces inequality in terms of lifetime health. By creating equal pathways no matter where one comes from.

A WHO Consultative Group on Equity and Universal Health Coverage was established to provide guidance on how best to address issues of fairness and equity:

1. Categorize services into priority classes: guiding criteria include the cost-effectiveness of services, those services which reduce inequities in service utilization, and those which best offer financial protection. Each country will prioritize differently according to its particular context.

2. Expand coverage for high-priority services to everyone: this includes reducing financial barriers (e.g. patient co-payments) to the use of these services, whilst increasing mandatory, progressive prepayments, and reducing barriers to pooling funds.
The WHO Consultative Group went so far as recommending eliminating patient financial barriers for these services.

3. Ensure disadvantaged groups are not left behind: in terms of actually accessing entitlements; for example low-income and rural populations often face many barriers to accessing services even if they are entitled to receive them free at the point of service.

Benefit design

Universal Health Coverage is often represented using a cube with three dimensions of coverage; these relate to benefit design choices.

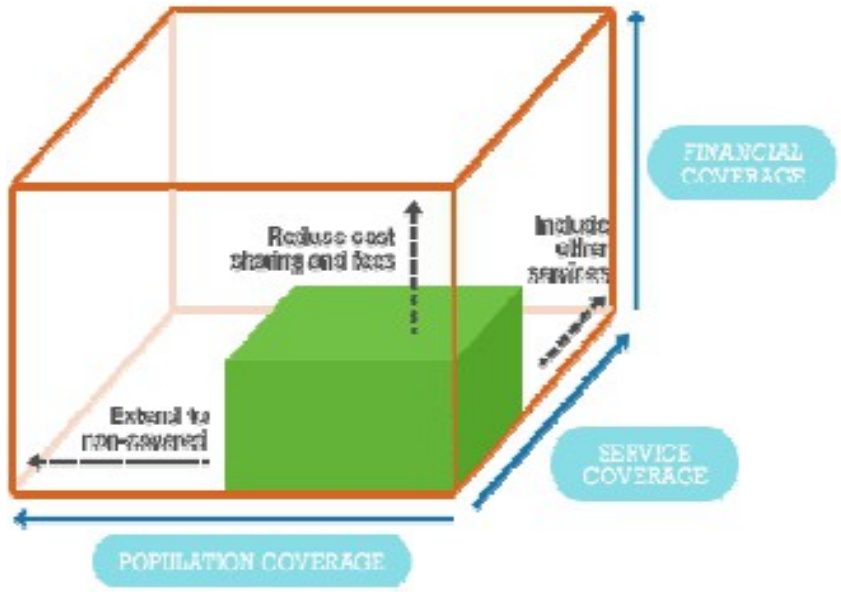


Figure: The three dimensions – population (*extend to non-covered*), financial (*include other services*) and service coverage (*reduces cost sharing and fees*) of UHC coverage (Courtesy of HFP-UHC WHO)

Population coverage

Population coverage refers to the beneficiaries of publicly funded health services; the people. This might include the entire population of a country, or a specific sub-group e.g. pregnant woman. In many countries, policy-makers are faced with decisions about whether or not to extend entitlements to the currently non-covered population.

Service coverage

Service coverage refers to the range of diagnostics, clinical treatments, and other commodities to be include in, or exclude from, the benefit package.
Many countries define the benefit package through one of two approaches:

positive list which defines explicitly those services to which the population is entitled

negative list which defines explicitly those services not included i.e. excluded.

Cost-effectiveness analysis is increasingly being used to inform decisions on which services to include in the benefit package, especially as new technologies and medicines become available; several other considerations are also very important however, as discussed earlier.

Financial coverage

Financial coverage defines how much of the service costs are funded through public subsidy, via the benefit package. For many services, 100% of the cost will be covered through public funding, with patients not asked to make any payment. For other services in the benefit package patients may be asked to make a financial contribution or co-payment.

Current situation



Figure: The current skewed coverage (courtesy of HFP-UHC WHO)

The inner cube is a simple representation of the situation in a hypothetical country (e.g. Kenya), showing gaps on each of the three dimensions of population, service and cost coverage.

The cube helps to visualize the types of decisions facing policy makers seeking to moves their health systems towards UHC. It also makes clear the reality of tradeoffs - no country provides everything for everyone, free of charge.
In practice, all three dimensions of coverage are frequently considered simultaneously,

for example a decision to provide maternity services (service coverage) to all women of child-

Aspirational situation UHC: the coverage cube

UHC health policy seeks to increase and diversify financial options which include elimination (progressively) of out of pocket expenditure to among others the marginalized and indigent populations. In the diagram, the outer represents an ideal situation where everyone has access to all the services they need without facing any financial difficulties. This is the aspirational part of UHC.



Figure: aspirations of UHC is 100 percent coverage

(Courtesy of HFP-UHC WHO)

"Provide all people with access to necessary health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective; and ensure that the use of these services does not expose the user to financial hardship".

Reforms to benefits entitlements

Helping countries to move their health systems towards UHC. Whilst the design of a benefit package is critical to clarify entitlements and obligations, both to those providing health services but also to potential users, translating these declared benefits into effective coverage requires action across all the functions of health financing: revenue raising; pooling of funds; purchasing of services.

In a blog Amref.org post by Dr. Mesack Ndirangu, The Country Director of AMREF-Kenya entitled **Crusade critical in achieving universal health cover**. He noted that the health insurance coverage in the country was around 20% and, that according to World Bank about one million Kenyans fall into poverty annually due to health related expenditure.

Other points included: Applauded the role of Health Bill (2015) now the Health Act in achieving a unified health system, coordination of county and national health systems.

The law's clause 54 would codify the UHC issue; make UHC a reality, a priority. Ensure sustained political goodwill. It states that the Ministry of Health shall ensure progressive financial access to health coverage. Make provision for social health protection.

That uptake of NHIF was still low with an immense potential for growth especially by getting buy-ins by those workers in the informal sector and hard to reach rural regions.

Borrowing AMREF's experience working with community health workers (a network of 500,000 CHWs spread across the country), Dr. Ndirangu proposed such a strategy that would ensure all health care providers and CHW became agents/'evangelists' for NHIF, do follow-ups/ reminders with household heads to ensure members continued updating their premiums regularly. They would create awareness and possibly in a more sustainable manner than happens with billboard, handbills, mass media etc. There was need to rethink the strategy. However, in March 2018 NHIF opted to engage a section of the youth to reach out to their communities to popularize the forthcoming universal health cover and recruit new members into NHIF scheme.

All personnel who are a critical point of contact at all levels between the health system and the patient become evangelists. He proposed a model Provider Initiated NHIF Enrolment (PINHIFE) as happens with HIV prevention PITC provider initiated testing & counseling.

The community places a lot of trust in CHW and CHVs since they were part of them. I NHIF could give them incentives in terms of commission agents. They would become the first line defense against financial catastrophe that could befall a household due to illness.

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CHAPTER 5
The Kenya Quality Model for Health (KQMH)

Overview

This chapter reviews the development of Kenya Quality Model for Health (KQMH). KQMH incorporates different tools for continuous quality improvement, the Plan-Do-Check-Act (PDCA) cycle etc. KQMH aims to provide a conceptual framework for quality improvement in health services and systems in the country. The document integrated evidence-based medicine (EBM) through wide dissemination of public health and clinical standards and guidelines with total quality management (TQM) and patient partnership (PP).

KQMH, it has been taunted could become a basis for accreditation of health care facilities in Kenya. KQMH model and Kenya Health Policy framework 2012-2030 form the basis upon which the proposed 'Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS)' is built. It also acts as a resounding board for its constructs.

5.1 Kenya Quality Model for Health (KQMH)

Originally referred to as Kenya Quality Model (KQM, 2001), was an initiative of the Kenya Government. It aimed to provide a conceptual framework for quality improvement in health services and systems in the country. The model integrates evidence-based medicine (EBM) through wide dissemination of public health and clinical standards and guidelines with total quality management (TQM) and patient partnership (PP).

It also defined quality improvement in healthcare as a process:

- To improve adherence to standards and guidelines
- To improve Structure-Process-Outcome of health services by applying Quality Management principles and tools
- To satisfy Patients / Clients needs in a culturally appropriate way.

Despite all the quality improvement processes KQM apparently was not participatory and its principles were not known by many which led to failure in its implementation (KQMH, 2011). The country faced implementation challenges that led to a variety of quality imperfections such as substandard health facilities, professional misconduct, non-professionals offering sub-standard services and a poorly regulated pharmaceutical subsector. The proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) hopes to partly address these challenges.

Apparently it seemed the Government never really got round to implementing the KQM. It therefore became necessary to review and update the KQM. The KQM was reviewed in the 2008-2009 financial year, renamed the Kenya Quality Model for Health (KQMH) and expanded to address clinical care, management support and leadership.

The Ministry of Health through the Department of Standards and Regulations launched the KQMH in May 2012.

This enlarged framework added an implementation guide to the standards and checklists, in an effort meant to raise the standards of health care delivery in Kenya through the Kenya Quality Model for Health (KQMH). After the launch, a technical working group was formed to work on a curriculum for training trainers and sensitization of the responsible people and groups in the counties, in line with the constitutional dispensation on devolution of health services.

KQMH is a conceptual framework for a holistic quality management system that systematically addresses a range of organizational quality issues with the main aim of delivering positive health care (Please see Appendix IV). It employs 5S-CQI-TQM stepwise approach. KQMH would serve as a useful tool in ensuring quality health care for all Kenyans. The KQMH implementation guidelines had also embraced the use of diverse quality improvement approaches and methodologies drawn from the best practices which were re-designed and customized to address the needs of the Kenyan health system. All health sector stakeholders are encouraged to use this quality model for their own measurements with regard to project outcomes (Technical report, 2013).

KQMH incorporates different tools for continuous quality improvement, the Plan-Do – Check Act (PDCA) cycle etc. (please see Appendix VI). KQMH aims to provide a conceptual framework for quality improvement in health services and systems in the country. The document integrates evidence-based medicine (EBM) through wide dissemination of public health and clinical standards and guidelines with total quality management (TQM) and patient partnership (PP).

Evidence based medicine (EBM) involves the development and dissemination of standards and guidelines; Total quality management (TQM) involves the application of quality management principles and use of master checklists and adherence to standards and guidelines. Patient Partnership involves the promotion of involvement and participation of the community. More about EBM will be covered in Chapter 8.

KQMH uses a checklist to 'score' performance of an organization against established standards. The scores can be used as an external benchmark of improvement over a period of time. Scoring can also provide an organization with an internal benchmark for its next self-assessment, in order to capture trends.

KQMH was developed in a consultative process involving stakeholders in the Kenyan health sector. The model has been developed for use by health facilities at all levels in both the public and non-public sector including Faith Based Institutions, private for no profit and private for profit institutions. It could also be used among organizations for some external benchmarking and comparison (CHAK, 2013).

KQMH was based the Japanese 5S and Continuous Quality Improvement and more Critically on Donabedian's classic 'structure', 'process', 'outcome' model for assessment of quality of care and 12 dimensions that attempt to cover all activities of a health care organization. These 12 dimensions are separated into three categories: Structure, Process and Results as follows (Please see Appendix V). Structure has10 dimensions: 1. Leadership; 2. Human Resource; 3. Policy, Structure & Governance; 4.

Facility; 5. Supplies; 6. Equipment; 7. Transport; 8. Referral; 9 Records & Health management information systems; 10. Financial management. Process dimension include 11. Client- Provider Interaction, Continuous Quality Improvement "KAIZEN". This Japanese concept "kaizen" is whereby one makes small constant improvements that eventually add up and make a radical difference.

TQM Programme Management (Reproductive health, Malaria, Expanded Program Immunization, HIV/AIDS/TB, Integrated Management of Childhood Illness and Non-communicable Diseases). While, *Results* include dimension from number twelve (12) chronologically from above: Users/ Clients Satisfaction, Performance of facility and Primary Health Care programmes, Staff Satisfaction, Society Satisfaction.

As far as Quality Improvement (QI) is concerned, Justin Glasgow (2011) made the following five recommendations to The National Quality Measures Clearing House (NQMC) spoke to broader concerns that must be addressed in order to ensure effective QI, using a PDCA approach:

- Make your QI efforts about quality, not about meeting a requirement.

- Successful projects are those that staff believe in and want to see become successful. Far too often, the people affected by a QI project (if not the QI team themselves) are told they must change in order to meet some arbitrary internal or external requirement like ISO or regulatory bodies.

  In these settings, the efforts routinely fail, either during the process or by immediate degradation of improvements after project completion. However, early communication in the process regarding the project value (for all customers and individuals affected by the QI) beyond meeting arbitrary requirements increases the likelihood that staff will be motivated to help the efforts succeed.

- Aim for real change, not just re-education. An all too frequent solution for improving quality in health care is to round up a group of individuals, take them to a seminar or workshop somewhere, tell them what they are doing wrong, teach them how to do better, and return them to work. Sometimes, if properly motivated, this simple educational approach may make initial improvements, but in the hectic world of health care, it is too easy to unconsciously return to old ways.

- While effective QI will include education, it must also involve an understanding of how poor quality care exists in the current process and then identify ways to change the process such that sources of poor quality are eliminated. No single intervention is sufficient on its own, but, with continued focus and process changes, hospitals can sustain a QI initiative.

- Empower and excite.

- Change is most lasting when those who provide frontline care at the operational level/point of service are involved and truly excited about the QI they helped to develop. It must be the frontline leaders who recognize a quality problem, communicate the need for change, and motivate those around them to overcome

the challenge. Additionally, it is these people who understand how a process truly occurs and can best identify the waste or potential sources of error. Only when there is true energy at the front lines for supporting and making a change is it possible to achieve long-term quality.

- Measure and evaluate. It is impossible to improve quality if there is no clear understanding about the current state of performance. This likely means multiple measurements before, during, and after a QI project. Sometimes knowing how performance varies over time can prove just as informative as knowing absolute performance at any single point in time. *"Knowing is not enough; we must apply. Willing is not enough; we must do."* Goethe. This quote is found in the forward of the masterpiece book on quality health care by the Institute of Medicine, *Crossing the Quality Chasm* (IOM, 2001).

- Also, measurement should not stop just because changes are no longer occurring. It's critical to observe how well change is maintained in the months and even years after a QI initiative.

- Start small, dream big.

- Policymakers can only make headway if the performance of health systems are measured. This would help them come up with more effective and efficient health interventions, which in turn will enable them to plan better and work faster to save more lives. Efficacy of health systems has traditionally been measured on the basis of access to services that is counting the number of people who visit facilities. Information about gaps in the system, data on the quality of services should reach health care providers, facility managers and policymakers. This will also require the use of technology and better data collection.

Remember, PDCA is conceived as an iterative cycle, and all QI approaches include some level of focus on continuous improvement and monitoring. As such, it is critical to set initial project goals that are reasonable to achieve. As an example, consider efforts to reduce hospital acquired infections caused by *Klebbsiella* and *Acinetobacter*; the initial project goal may be to reduce them by 50%, then in the next iteration by another 10%. Remember *No one* should get sick seeking care.

Working in this manner allows teams to identify and eliminate different sources of error. It also means that over time the team may eventually achieve a bigger goal, such as complete elimination of burst abdomen post laparatomy, urinary tract infections, ventilator associated pneumonias and *Never events* –" events that should never happen" e.g. foreign body left in after procedure, blood transfusion incompatibility etc.

Tackling small, achievable goals will steadily improve quality while maintaining excitement and confidence. Sometimes I wonder if our world of instant gratification is getting in the way of being interested in change. As we work we need to appreciate generation gaps, the 'instant gratification generation' needs continual reinforcement that they are doing a good job.

But we know that change does not happen immediately most of the time, instead it takes a lot time spent in the weeds. It's hard work! When I took a class in relational

communication I was enamoured by it! I learned a lot about communication and emotional intelligence (EI). Communication for instance is one of the most important skills in life. These are great concepts especially with the generational changes, it takes soul searching to know how to cultivate great relationship skills to be a good leader. (See **Generation gaps** below).

Performance improvement has become a forefront in health care related education, administration and practice. KQMH laid out the process of creating the linkages to other existing quality improvement approaches including International Standards Organization (ISO). This integrated approach would form the basis for ISO certification of health facilities.

Generation gaps

I remember when I started at my first nursing job working day shift on a cardiac progressive care at a tertiary level Accidents and Emergency Department, I never once was reinforced. I didn't feel like I was doing a good job. The day I decided to share with my boss that I wasn't happy where I was and I was going to start looking for a new job, she said one of the nicest things to me. She told me that I was one of the best nurses and she didn't want to see me leave, but understood my circumstance. Why in the 2 years I was there did I never hear similar words? It really affected me ...and it's part of my generational need.

(Shared by J M (student) online class discussion *Health Systems & Management NURS6603, Fall 2015*, University of Colorado Denver).

Some analysts have taken to blaming the younger generations, saying that they are entitled, self-centred, too absorbed in their smartphones to work. While some of those complaints may have some grain of truth to them, the younger generations may not be entirely to blame, the older ones are too; for their sense of entitlement, being fixated in some past and a patronizing attitude. (Modified from Mark Manson blog on Pocket Hits).

In terms of turn over and job satisfaction, 20% of new nurses were leaving their position within the first one year in the US. These were variously described as the millennial generation (born between 1982 and 2000 - the youngest heading for 20s and the oldest 30s). They formed the largest cohort demographically. They were more likely to experience burnout and compassion fatigue compared to more seasoned and earlier generation colleagues (Lippincott Nursing *New* Center *s*, May 27, 2017 It was perhaps harder to say the same for Kenya. The nurses in public health facilities were mainly an older workforce, perhaps we could talk of those born in the 60's & 70's. Facilities wanted to get by on bare minimum. As they kept on burning out the experienced ones, older nurses were retiring yet they were not hiring new ones [www.scrubsmag.com
Is America still facing nurses shortage?]

KQMH three pillars: Evidence-Based Practice (EBP); Total Quality Management (TQM); and Patient Partnership (PP) are backed up by 7 key principles: customer focus, leadership, people involvement, systems approach, process approach, continuous quality improvement, factual approach and this author adds the mutually beneficial consumer-supplier relationship as a principle of quality management.

The main objective on training suggestion by KQMH 3.2.3.4 Continuous Quality Improvement was: equipping the staff with skills to provide better suggestions by describing the problem objectively and establishing the background to the problem. The Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) sees this as a gap to makes some input.

KQMH advocated for development and use of clinical nursing standards and guidelines, clinical/nursing audit, and performance assessment through the use of check lists. Other Quality concepts propagated include: Just-in-Time; Nursing/Clinical Audit; Clinical Pathway; Performance and Quality Improvement processes; Continuous Quality Improvement models; and Quality Circles among others.

KQMH recognizes that health care institutions depend on their customers and therefore should focus on customer orientation and understand current and future needs. Institutions should meet customer requirements, strive to exceed expectations, build up a relationship, show commitment, provide feedback, provide monitoring and evaluation, and display and communicate patients' rights.

Due to the critical role that KQMH played in the conception of this book it has been grossly mentioned in literally every chapter. A seminar on stakeholders on quality health care from Kenya and beyond in June 2013 recommended that KQMH be used as an accreditation standard for health care institutions in Kenya (Technical Report, 2013).

Therefore a lot to do with its concepts will continue to come out. A PDF download is available from 'Implementation guidelines for the Kenya Quality Model for Health (KQMH)', Ministry of Health Kenya.

We can *Think big- Act small, Start now*. If we can all aspire to something, not just for ourselves as individuals but for our country, surely we can achieve excellence. As Aristotle put it "We are what we repeatedly do, excellence then is not an act but a habit" If indeed Konza Technopolis City is not a pipe dream, then dreaming of an excellent public health system is just as real.

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CHAPTER 6

'Best Care Anywhere' Organizing Framework for Interrogating Health Care Provision in Resource-Constrained Settings

Overview

This chapter introduces the Best Care Anywhere Organizing Framework for Resource-Constrained settings (BCAOFR-CS) and the theory behind its development. The framework addresses issues of disparate resource allocation, patient issues and staff attitudes among others. Its propositions are intended to stimulate reflection, inquiry and new insights on access to quality health care in resource-constrained settings against a backdrop of some known and emerging dynamics that apparently influence access to quality health care in Kenya.

It is made up of six constructs; each of them poses some begging questions for weighing, considerations and decision points. Questions that may not have immediate answers but which individually or corporately can be thought through.

"The important thing is not to stop questioning." - Albert Einstein.

BCAOFR-CS envisions a 'Compleat' health care provider having all the necessary desired elements or skills to perform in resource-limited settings of Kenya (or elsewhere) by utilizing constructs in this framework. It is in line with Kenya Quality Model for Health (KQMH) and Kenya Health Policy Framework 2012-2030 among others. The strengths, weaknesses, assumptions, applicability and implications of the framework are discussed.

6.1 Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS)

6.2 Background

The BCAOFR-CS framework was originally conceptualized by this author, then Nurse Manager, Critical Care Services at a Levosix Hospital (not its real name), Kenya in 2013 as part of quality improvement. Its vision as a process began to take shape following a survey by the author and workmates working in critical care units [then, 6 beds Critical Care Unit (CCU) & 3 beds High Dependence Unit (HDU)] serving a 400 bed hospital in western Kenya] report entitled; 'Walkthrough survey of acute rooms at a level six Hospital a rapid appraisal' in 2013 (some identifying features have been changed).

In the recommendation section of this quality improvement study the maiden framework [cited in another study by Kamau (2012)] was used to illustrate how the various disparate resource allocation between units, bad practices, staff attitude, and clients' passivity impacted on assuring/limiting access to quality health care. It had been observed that patients being discharged to these step-down acute rooms did not do well and mortalities were observed even among some of the stable patients, hours to days after discharge to the wards. Sometimes patients were rushed out of the ward as fast as they are admitted to make room for the next admission

without proper follow up in place - due to compressed time and space in critical care; patients were being discharged to the wards before they were stable enough.

Acute rooms were considered a necessary step-down from CCU and HDU or holding grounds whenever the critical care units were unable to admit or were forced to discharge patients due to constrained bed space. For a great majority, it was not possible to book a bed in any other CCU(s). Nairobi the next option was 350Km away. Making it by road was a nightmare not worth the risk for many acute & critically ill patients. The complications to acute & critically ill patient travelling over long distance by road were; that some would not make it to the destination or might be too unstable as a result of the journey, sort of 'transferring the mortality to someone else …'.Only a few Kenyans can afford to charter an air ambulance.

6.3 Theoretical underpinnings

A theoretical framework represents the beliefs on *how* certain phenomena (or concepts) are related to each other (a model) and an explanation on *why* you believe that these variables are related in that way (a theory). Meanings of the concepts are explained, as well as their relationship to each other.

The proposed BCAOFR-CS framework is descriptive in purpose and was developed deductively from generalizations of insights (Rycroft-Malone & Bucknall, 2010, p27, 231) from collective wisdom; system wide (i.e., governance, health financing, logistics, human resources, health information, and infrastructure). Drawing on experiences of the developer within the nursing practice care environment, working in resource constrained public health care facilities in Kenya (See Appendix VII).

It is inclined more towards behavioural models and frameworks some which were covered in Chapter 4 and 5 of this book. These included: *Penchansky's Model*; The Institute of Medicine (IOM) *Model of Access Monitoring*; *The Behavioral Model of Health Services Use;* Andersen and Newman *Framework of Health Services Utilization*; *Conceptual Model to Assess the Underlying Factor* and *Kenya Health Policy Framework 2012-2030; Kenya Quality Healthcare Model Kenya Quality Model for Health (KQMH)* among others. Other models will be covered when we come to evidence based practice related chapters. It is presented as skeletal propositions intended to stimulate reflection, inquiry, new insights and levels of analysis on quality health care in resource constrained settings in Kenya.

The framework envisions that it is possible to have a compleat health care provider having all necessary or desired elements or skills to perform in resource limited settings of Kenya (and elsewhere), who is in a position to be transformed by the constructs of this framework and would be in a position to utilize it in enhancing access to quality health care. This phenomenon evolved as an emergent reflection on what was already learned during literature review and not necessarily out of a prior theory, though efforts have been added to put it into this context. Such a phenomenon might be related to what was explained by Polit & Beck (2012 p.487).

Access to quality health care is a much sort after goal, so is its sustainability and continuous improvement. Just like any other service (e.g. education, security, retailing, telecommunications, banking, media, hospitality, repair and maintenance etc.) in resource-limited settings, Kenyans tended to overlook the quality of services until they become consumers or are deprived of the very service in one way or another. But unlike other industries, it is routinely shocking what consumers will tolerate in healthcare that they would certainly never tolerate in any other industry e.g. hospitality, banking, education etc.

It is possible that many of health care providers have only a basic idea of how the healthcare system actually works, and the average citizen knows far less. Yet developing countries like Kenya continues to struggle with health sector reforms amidst challenges such as inadequate resources. The decisions & problems we face are becoming increasingly complex. This author yet considers himself a lifelong student in health systems, leadership and administration. It is a hard undertaking, but it's worth it.

While models on access to quality health care have informed policy in the developed countries, research to support relationships depicted in the models were being conducted and ongoing. In the case of Kenya Quality Model for Health (KQMH), concluded implementation studies citing it were not accessed by the author at the time of compiling this study although two piloted projects were underway.

To the best of this author's effort Kenya Health Policy framework (KHPF) 2012-2030 did not mention KQMH in its entire document? The assumption that neither made any mention of the other may be correct. It would be fair then to assume that the BCAOFR-CS framework is in a small way a timely contribution towards merging and supplementing the KQMH model and Kenya Health Policy Framework 2012-2030, even if on a quality improvement basis.

Re-conceptualization of the KQMH model might become possible when implementations studies and insights about it become more available. Fortunately, some dissemination briefs and reports on KQMH by faith based health care facilities run by Church Health Association of Kenya apparently were the only show cases this author could access (CHAK, 2013).

It is interesting that a caveat was found to be in order when beginning implementation of KQMH such that its developers cautioned in section 3.1.2.1.1 Preparatory Phase, Step 5, 'DO NOT start with sections or departments that are facing lots of problems as it will take a long time to solve the problems and build a "showcase"' (KQMH, 2011, p14). It may be tempting to think that such a recommendation meant we could wait for things to improve. That was why the BCAOFR-CS framework was mindful to take this into account since in many resource-limited health care settings in Kenya, such forewarning raises several questions begging for answers as will be seen in the proposed framework.

In June 2013 a seminar brought together key Kenyan stakeholders and health care quality leaders from other countries to share experiences and ideas on successful models for leading and supporting improvement of health care at all levels of the health system (as seen in Chapter 4). This was referred to as the 'National Policy Seminar Kenya' (Technical report, 2013). The conglomeration raised several issues upon which this author wrote this framework, albeit attempting to answer them in a very small way.

They focused on several questions on quality improvement; these were: (i) How did the improvement effort(s) you have experienced start? (ii)Who championed it (them)? (iii)How was commitment sustained? (iv) How were improvement priorities set? (v)What infrastructure was created to support improvement? (vi) How did it work?

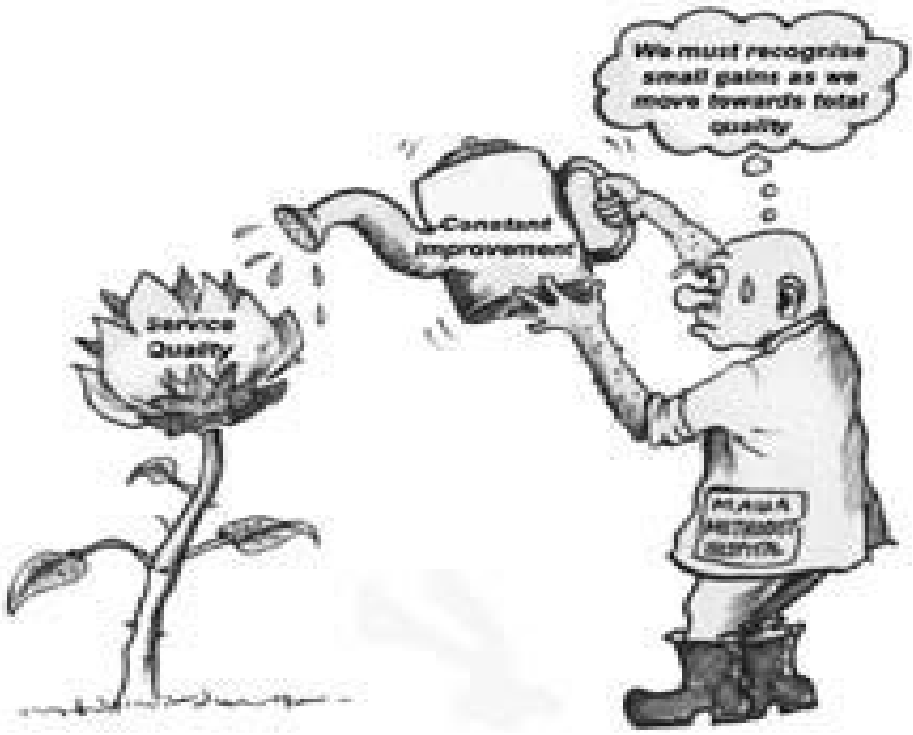
These questions on quality improvement were expounded and grouped further into four sets as seen below:

- What improvement approaches were used? How and why did you choose them? How did they work? How did you resolve the balance between minimal standards and best practices? How did you review progress? How did you communicate and coordinate? If you were to undergo this experience(s) again – what was important

that you would want to see repeated?

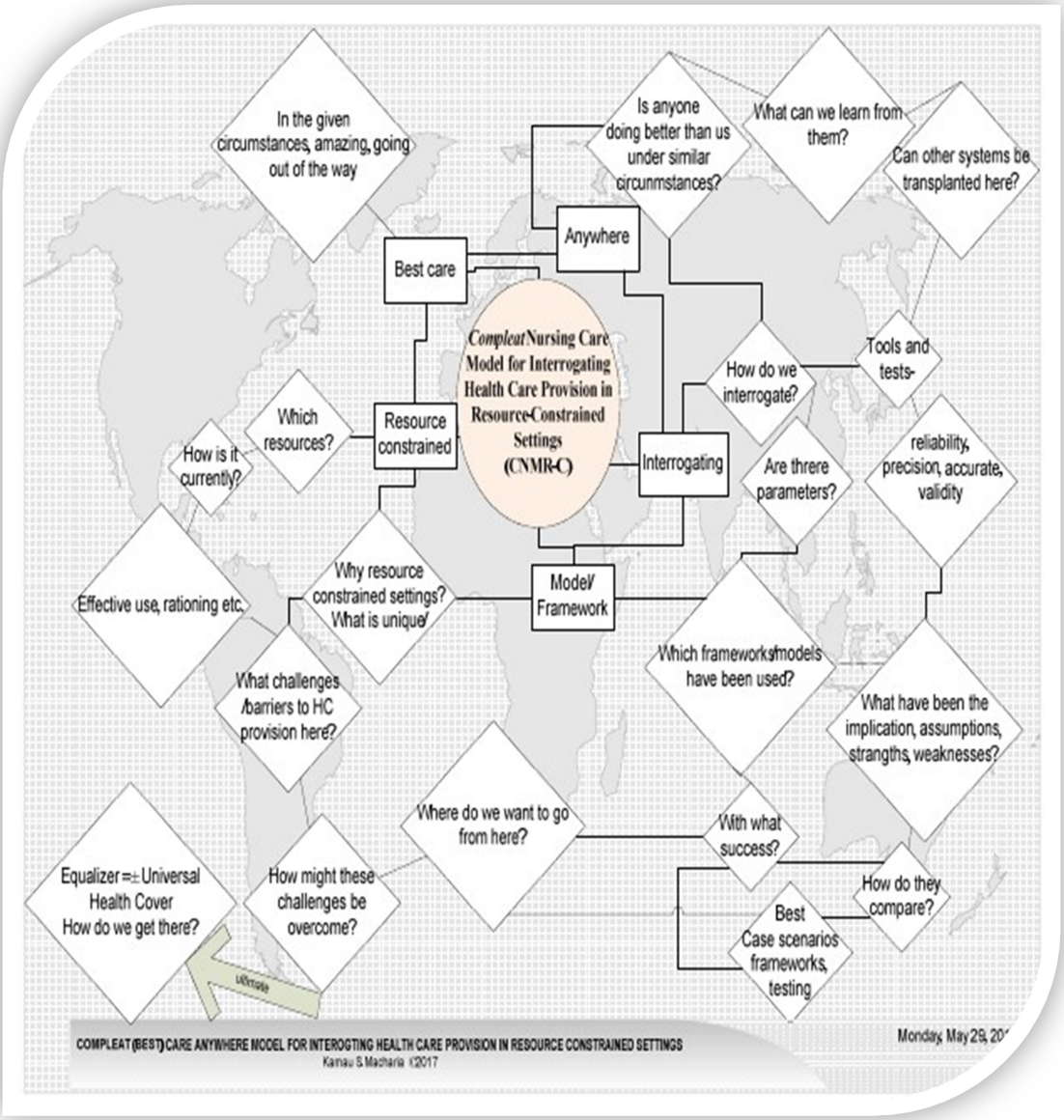
- What is the role of accreditation? What are the next steps and directions for accreditation in Kenya?
- What would you advise the Ministry of Health (MOH) of Kenya related to national improvement strategy?

The forum agreed that the MOH should set priority areas of focus because to try to improve everything at once would overburden the system. Key to these priorities was to empower providers to make the changes that needed to be made and foster shared learning (Technical report, 2013). Therefore, the seminar forms a helpful resounding board that inform concepts discussed inside the framework shown on the next page.



Cartoon above reads as follows: ***'We must recogize small gains as we move towards total quality through constant improvement of our service quality'***

(Courtesy of Maua Methodist Hospital, in *CHAK Times* 42, 2013)



6.3 Purpose

To introduce a framework BCAOFR-CS which acts as an organizing framework in understanding and relating studies on quality health care and to give organization for future advocacy, research, education and development that were found to be deficient and needed to be concentrated on. The framework therefore provides a 'fit' between diverse themes related to quality health care which flow throughout the previous chapters of this book and the constructs below to try and draw patterns of association.

The primary intent of Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) is a tool to provoke service providers (be they individuals, leaders, teams and organizations) in health care field to discuss the components of their profession and hopefully to a lesser extent guide their practice. However, the framework appears to function

more as a definition of various aspects of access to quality care in resource constrained settings and their roles in practice than a tool to guide practice.

To assist health care providers identify important factors inherent in them or their clients, or the system that they would need to address in order to facilitate provision of quality health care in resource constrained settings. It's a realistic call to professionalism, rising above the challenges in a changing, yet resource-limited environment.

Even in the midst of many constrained circumstances as health care providers, we still owe it to ourselves to ensure access to quality health care services. Thus this framework could be applicable in many situations and is flexible if combined to augment or be augmented by other models/frameworks to counteract deficiencies in either.

It was developed in line with the call for development of trustworthy ideas for better implementation and outcome of Continuous Quality Improvement (CQI) activities proposed in Kenya Quality Model for Health, 2011. Section 3.2.3.4 of KQMH document also encourages staff to generate a great number of improvement suggestions and show how these improvements could be implemented.

According to Bozak (2003), if the culture is not one supportive of questioning practices, substantial change would be required in both organizational systems and individual attitudes. Helping staff and consumers question practices is therefore an overriding goal of BCAOFR-CS. Furthermore, systems change was most successful if it was a conscious, strategic effort rather than one left to chance.

6.3 Assumptions

BCAOFR-CS makes the following assumptions:

- That there are quality indicator questions that can be asked on barriers/facilitators to access quality health care unique to resource-constrained Kenyan context (which might apply also in other developing countries).
- That in theory, quality health services can be provided in the most minimal service delivery setting.
- The consumer has a say on services they receive and even when he does not (which is unlikely), he needs to be informed.
- If the provider were to become the consumer/or were deprived of the very service they might look at things differently, perhaps become more compassionate.
- Best care anywhere would be possible if we got easy one-size-fits all solution for continuous supply of basic cross cutting consumables, dressings, medications and equipment. Unfortunately this was not going to be since it's an age-old problem. But then we could discover new solutions to old problems, or lead to more efficient processes.
- The framework is not depicted as proceeding in a linear and sequential way, infact the process can start anywhere in the framework depending on the individual, unit, team or organization. It would be fairer to assume that there is praxis

approach between the constructs such that the development of the relationships is neither linear (always moving forward) nor repetitive (cycling through the same things again and again).

- A multidisciplinary exemplary performing health care provider is envisioned in the framework.

Further, postulates that nursing is a unique discipline within the health care workforce in the delivery quality health care

6.4 Constructs

A construct is an abstraction inferred from situations or behaviours. Abstractions of particular aspects of human behaviour and characteristics are called concepts or, in qualitative studies, phenomena. We can distinguish concepts from constructs by noting that constructs are abstractions that are deliberately and systematically invented (constructed) by researchers. The terms construct and concept are sometimes used interchangeably but, by convention, a construct refers to a more complex abstraction than a concept (Polit & Beck, 2012).

Constructs are the means for linking the operations used in a study to a relevant conceptualization and to mechanisms for translating the resulting evidence into practice. When referring construct(s) [in the proposed Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) framework] it is assumed there is a fit between conceptual definition and operational definition.

The framework is designed purposely to stimulate health care workers to question and potentially change behaviour and practice. It describes access to quality health care in the form of heuristic, begging questions and decision points on its characteristics, qualities, and properties in each of the six constructs. The constructs are not as succinct but will be with time. Being succinct refers to whether or not this framework can be explained in as few (a) steps as possible. There can be several variables of these constructs since one can start anywhere and the constructs would still be logically organized. A Construct according to *Wiktionary* is a notion, idea or concept. A schema on these constructs is raised in figure below:

The criteria that all the constructs being met in any one particular situation must not be met but a majority of them need to be to qualify as quality healthcare in a resource-limited setting.

Some constructs check on each other e.g. one that checks for medical errors is checked by what care one would wish for themselves or their significant other(s). Client satisfaction or the lack of it can be related to whether or not there was a continuous supply of basic equipment, medications in healthcare.

The broad-based statement of each construct creates room for generation of possible scenarios upon which some questions can be posed, e.g. did you know someone in the health facility for you to be attended? Were you by any chance one of the VIPs (very important persons), or did you have to raise complaints or threatened to follow up with management, ability to sue? Which can also bring in, did you give (or would you give) a token before being attended or after that etc. etc.?

6.5.1 Construct No.1. Does giving a service yet no harm comes to the patient mean or not mean that we did the job well?

The first obligation of health care is to "do no harm." Quality and safety are inextricably linked. *No-harm event:* A patient safety event that reaches the patient but does not cause harm. "*Near miss*" or "*good catch*": A patient safety event that did not reach the patient (The Joint Commission, 2015). Near misses also referred to as close calls accordingly are "free lessons" about the varieties of human error, the local circumstances that trigger them, and the "upstream" systemic factors that can give rise to them. We cannot eliminate human fallibility. It is deeply rooted in the human condition but flukily stroke of luck cannot be equated to delivery of quality health care.

Might we be leaving so much of patient management outcomes to chance? Medical staff often regrets what the medical staff "could have" and didn't do. The chasm of errors needs to be bridged (IOM 2001 report). Do our clients in the rural areas have the presence of mind to question the decision made by the health care workers who they hold in awe, at times expecting nothing short of a miracle? How empowered are they to press for their rights?

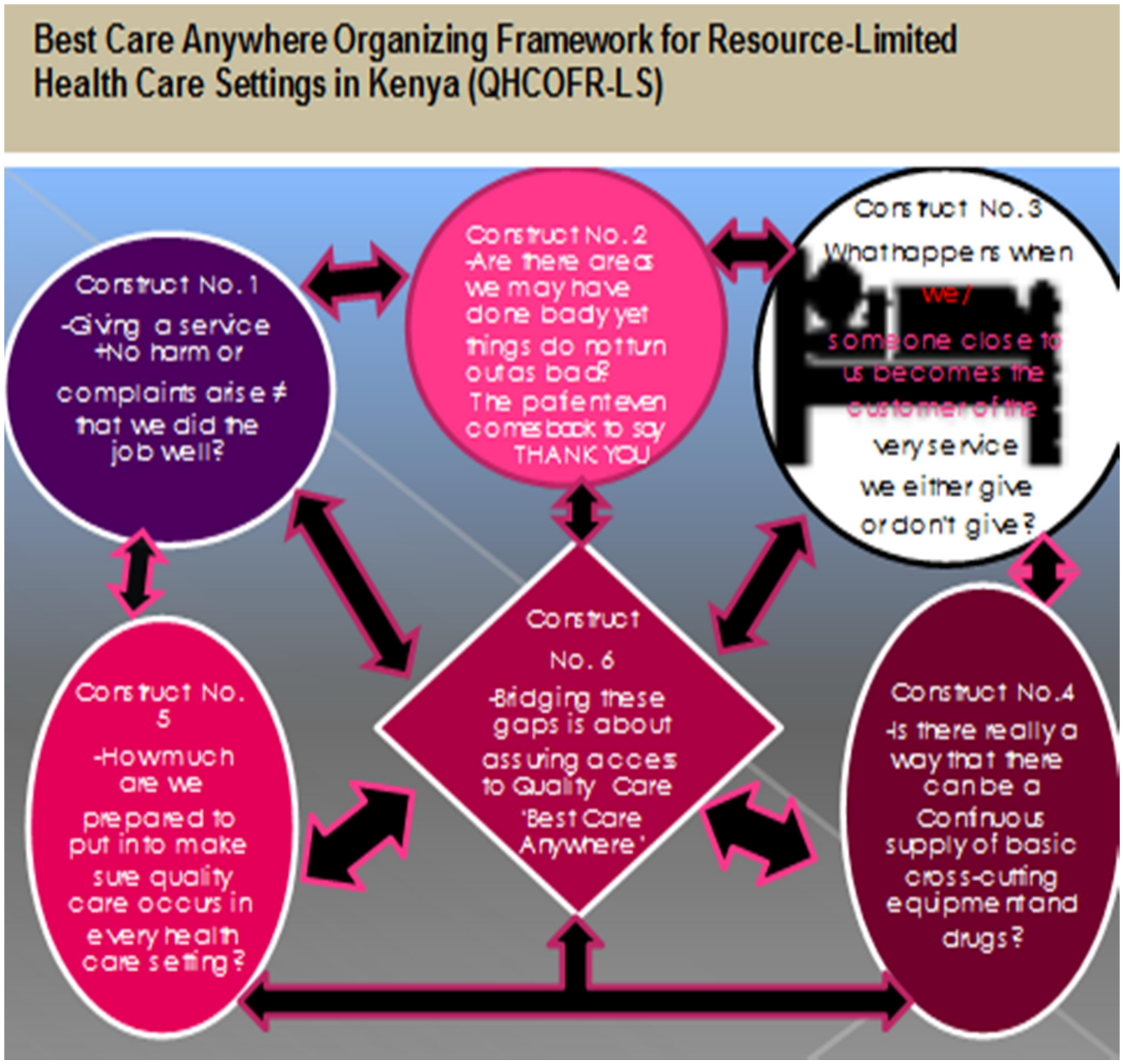
Does passivity mean that really they did not have a complaint to make regarding the quality of services offered and the professionalism of medical personnel? In their discussion of access, Aday and colleagues (1980) stated that people who say they are satisfied with their care encourage the acceptance of the status quo and those who are dissatisfied signal the need for action. The reasons for the community's reluctance to appeal could be because they do not think it is their right to do so (Bukachi *et al.,* 2014).

How can we have the patient as an active participant in decision making regarding their care? Does each team member demonstrate competence appropriate to his or her role and responsibilities that the patient is thoroughly satisfied with their service? Are health care providers being held accountable by those they serve, those who pay the price for poor and inefficient care - consumers and purchasers?

It would be akin to a miracle if medical workers could sit down with every patient long enough to listen to all their complaints, their medical history and get a chance to ask all those relationship building questions… But the truth is that patients are too plentiful, time is too tight … So patients must make the most of each visit to the clinician. With this understanding, it has been said that medics just like other professionals spend years learning how to read, write, (may be some art in speaking) but none in how to listen. If anything most people listen with the intent to reply, get their point across, offer a solution but not to understand. Experts in communication underscore the need to seek first to understand than be understood.

The http://www.thebeehive.org in its forum *Visiting the Doctor* advises them to: be prepared with a check-up checklist like your health depends on it… because it does. According to Public Private Partnership, your personal health assessment is best done by you http://www.ppp-healthkenya.org/.

This is an interesting area we can improve on to provide person-centred, compassionate and empathetic health care that would have a great impact patient's perception of the care they received. If the health care provider was to deal with a difficult patient or family member and was able to put his/her feelings and perceptions aside and treat a person with genuine respect and caring, does that patient feel that they received better care even if mistakes were made?



Constructs to the Best Care Anywhere Organizing Framework for Resource- Constrained Health Care Settings (BCAOFR-CS)

Legend: +No (either/neither happened); ≠ (construe to mean or not mean), mirror image- self reflection on practice

(Source: Kamau S. Macharia© 2018, "Best Care Anywhere Organizing Framework for Resource-Constrained Health Care Settings (BCAOFR-CS) in *Interrogating Health Systems in Resource-Constrained Settings Frameworks for Quality Health Care in Kenya*)

Conversely, I have seen many times how a patient could get upset with a nurse they didn't perceive as "nice" and complain about the care they received even though that nurse had just skilfully brought this patient through a potentially dangerous, life-threating situation. Does patient-centred care increase patient satisfaction and, furthermore, if present, does that increased

satisfaction produce increased patient satisfaction scores?

Just because the day has passed, the visitor has left, the audit is over, that snooping around '*good for nothing* administrator, 'nagging' patient/relative who was discharged does not necessarily mean the matter was resolved. One daring veteran staff said to all who cared to listen that 'some problem were not meant to be solved, that there were those who benefitted from the status quo, even though it might kill them one day'. May be he was right.

To address patient satisfaction there was need to see problems from their point of view, a need to change some perspectives of our care plans beyond the bedside. This is because it has become evident that a lot of issues that affect patient care rarely get documented in the patient's documents yet these are the system problems that cause frustrations, injuries, delays and even death. Issues are passed on verbatim, assumed to have been solved, even if for just that one day (living-one-day-at-a-time).

For a start, document them by trying to focus on the problem, and not advocating (or hinting) a particular solution (e.g., "Interruptions to operating theatre receiving area nurses' work resulting in long turn-around times," not, "receiving area nurse delays due to units calling instead of faxing lab works results to theatre").

If the customer is apparent on the issue, it should be stated from the perspective of the customer (e.g., patient for surgery was delayed waiting for lab works results from the units). Bring the problem to life: magnitude of the problem, where and when the problem occurred, and the problem's impact on the core business. This would help in getting the most basic reason why the problem occurred in the first place; develop countermeasures to prevent such problems in future with follow-ons.

May be if we focused on this angle we might be surprised that myriads of issues that directly or indirectly affect patient care would more likely get attention. Some people might argue; does it become more serious a problem than it was? This author's take on this is that it would improve the outcome for every other patient a great deal. No one wants to be linked with having caused an adverse patient management outcome and especially if it touches on servicing department and senior management. If and when the problem is theirs, put it at their doorsteps using the patient's notes.

There is so much that operational level/point of service staffs have to bear by virtual of *being on the firing line*. If we expect to go any further, it is about time we stopped covering up issues and hoping they will go away somehow. Expose them where they matter most. First and foremost by documenting them there first.

Though this approach has not been researched (by this author, though has had tried them several times and the results had always been amazing, on very few occasions will they fail to get attention or a speedy resolution) we could borrow something similar from manufacturing (Toyota Motors has had an *A3* problem solving going on for years and it seems to follow this approach. Please see section: 6.9 below for some examples of A3).

Values such as trust, equity, accountability, and fairness are concerns for the ordinary Kenyan. Anecdotal evidence showed that being attended to in a health care facility without the client being required to undergo any (or some) of the following experiences was described by many of them as quality care indeed:

-having to wait for too long

-not required to know/be known to any of the health care staff

-being asked to go and purchase medications, non-pharmaceuticals or being referred to a clinic outside the hospital run under the proprietorship of the same health care provider or an accomplice.

-move up and down the floor for this and that other service

-being informed of what was going on, what to expect next and what was expected of them

-less than adequate time to explain their problem to the clinician

-last but not the least, 'whether prior to or after being attended to, one was coerced to part with or volunteered to part with' what some residents called, 'something small' also-known-as (AKA): *ka*-something or *ko*-something, *chai* (tea) etc. it amounts to some form of corruption. Or is it a token as we shall see below? A public officer may not have criminal liability (since sometimes it is difficult to prove one was guilty beyond any reasonable doubt even where circumstantial evidence existed), but public servant has a moral obligation to say No to corruption.

Contextual factors in corruption apparently affected every other sector, everyone pointed out who, where, when but not on how it could be reined. With that kind of attitude and a fairly sceptical citizenry it was impossible to make much progress in almost all sectors including health.

Informal or unofficial payments are often a direct reflection of poor transparency in a health system. Transparency is important here in terms of the extent to which people are aware of their entitlements and obligations, for example, what services they are entitled to access, and what if any rules they must adhere to, such as making a co-payment, paying higher than necessary price for drugs. Being fully aware of service entitlements can empower people to obtain the services they need. If people are not clear about their entitlements, they may pay for services which should be fully subsidized; this, in turn, can lead to worse financial situation.

6.5.2 Construct No.2. Are there things we may have done badly but still no harm comes to the patient?

Some things we may have done badly but still no harm comes to the patient. The patient even comes back to say THANK YOU! It is not unusual that among rural population in Kenya one will want to reciprocate, a gesture common among many African cultures. A token of appreciation to their health care provider [in some cases the recipient may not even deserve it going by the sub-standard service they delivered and oftentimes encourages corruption as was cited in KQMH, 2001)].

However, In the African traditional context when a villager felt sick, he was almost certain to approach a healer with a chicken as a gift expressing deference/esteem to the healer's knowledge and status in the society. Messages about a gift from a patient to a health care provider are unpredictable or equivocal to the extent there may be multiple understandings of the intention of the gift in contemporary settings.
Infact willingness to pay might not be synonymous with ability to pay or the feeling that it's alright to do so. There would be need for additional information to decide which of the multiple interpretations was the best fit. Instead of going into all that, there ought to be a policy discouraging this practice and any such be treated as corruption (unless proved otherwise).

Patients are, by definition, vulnerable people. Patients are sick, injured, old, disabled, gullible or very young. Therefore, Construct number 2 is cognizant of *The Sick Role Model* (Parsons, 1951);

one of Parson's underlying values that defined the behaviours of both the sick and those providing treatment was: Vulnerability of the sick-'Because they are passive, trusting and prepared to wait for medical help they are vulnerable and open to exploitation by others'.

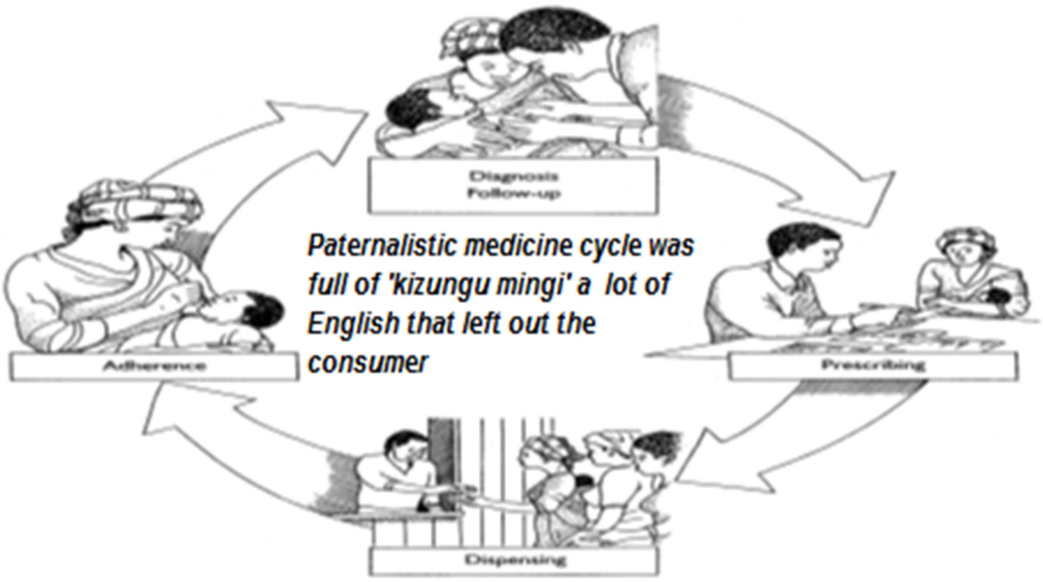
Brigit Obrist (2006) did a masterpiece that looked at the health from social sciences perspective, *Struggling for Health in the City: an Anthropological Inquiry of Health…* An aspect that this author admires in the writing was the simple down to earth English- Swahili interface on issues of health from mainly urban Dar es Salam Tanzania. In *page 133* Appearance - no sickness. She/he may be sick… if does not look happy – *kama anaonekana hana furaha*. Fuglesang (1982) contended that by and large, health is produced for consumers by the definitions offered by the medical establishment and by the vested interests of the pharmaceutical industry.

The Health Bill 2015 (Health Act 2017), provided under **Duty of users** Section 13 that:

> A user of the health system has the duty, in so far as it is within users - (a) to adhere to the rules of a health facility when receiving treatment or using the health services provided by the establishment;
>
> (b) to adhere to the medical advice and treatment provided by the establishment;
>
> (c) to supply the healthcare provider with accurate information pertaining to his or her health status;
>
> (d) to cooperate with the healthcare provider;
>
> (e) to treat healthcare providers and health workers with dignity and respect;
>
> (f) if so requested, to sign a discharge certificate or release of liability if he or she refuses to accept or implement recommended treatment. (Also see **Saving up problems for the doctor…** below).

Saving up problems for the doctor…

Often patients will "save up" health concerns and try to address these multiple concerns in one office visit...at least that is what I do sometimes. However, providers are not cooperative or sensitive to patients "saving-up" concerns and my doctor told me that I could only address one problem at a time. I had a choice: address the shoulder pain and receive an order for physical therapy or obtain medication for hypertension. I felt this was more of "doctor-centered care" versus "patient-centered care". Kenyans were aware of pharm commercials: *Maumivu yakizidi muone daktari* or should it be *nenda uonekane na daktari*. Paraphrased from Swahili - If whatever remedy we are recommending does not work/if pain persists, see a doctor. (Shared covertly by a colleague)



[Courtesy adapted from the *Drug Use Cycle* NASCOP]

This author concurs that to a large extent this still applies, although the Kenyan patient today would have a more pro-active participation in the care. But generally, Kenyans held the health care workers in high regard, while the paternalistic approach is not unusual among many medical workers. This assumes that when ill, individuals are frequently imperfect judges of their own welfare. Healthcare providers act as agents, identifying need on behalf of patients argued Maynard (2013) in *Health Care Rationing*.

Priorities are determined by the provider's liberty/professional situation in assessing the patient's condition. Consumers were generally not privy to information about quality and competence. Very little was known by the patient about the relative cost-effectiveness of different treatments or even where it is. Beneficiaries were dependent on the system. Since the easiest aspect of health status would be to measure those who lived or died, as such can be identified only as statistics, the discussion is dominated by mortality (and morbidity) data (Maynard, 2013 in health care rationing). Another characteristic described in health care rationing is that beneficiaries are usually dispersed and rarely would a provider know where the patient came from nor where they went after getting well/or worse.

This may also be influenced by the evaluative health status by health care provider alluded to in the Andersen model (1995) and others:

-Patient must submit to bodily inspection, high potential for intimacy, breaches social taboos. The patient might find himself or herself in an awkward position.

-Patient/ provider relationship unequal; requires a high level of trust. Health care delivery is a very personal, face-to-face transaction. The role of power in patient-provider interactions is underscored. Many times the health care provider is one in social control and the patient has to concede if they expect a positive outcome.

-It becomes all the more necessary to introduce the people we serve as our clients as opposed to patients. A client is one who is considered to be a legitimate member of the decision-making team, who always has some control over the planned regimen, and who is incorporated in his or own care as much as possible (Ericson et al., 1983 p. 253). This is to differentiate from the

patient who is given aid, instruction, and treatment with the expectation that such services are appropriate and that the recipient will accept them and comply with the plan (Ericson et al., 1983 p. 254). As indeed the saying goes 'patient prevents, doctor treats and God heals'.

- The individual characteristics of the professional are likely to play a greater part in service delivery than in many other domains. Whether the health care professional chooses to go the extra mile is likely to have a far greater impact on health care than elsewhere (Page Ann, 2004). These are ordinary people doing extraordinary things.

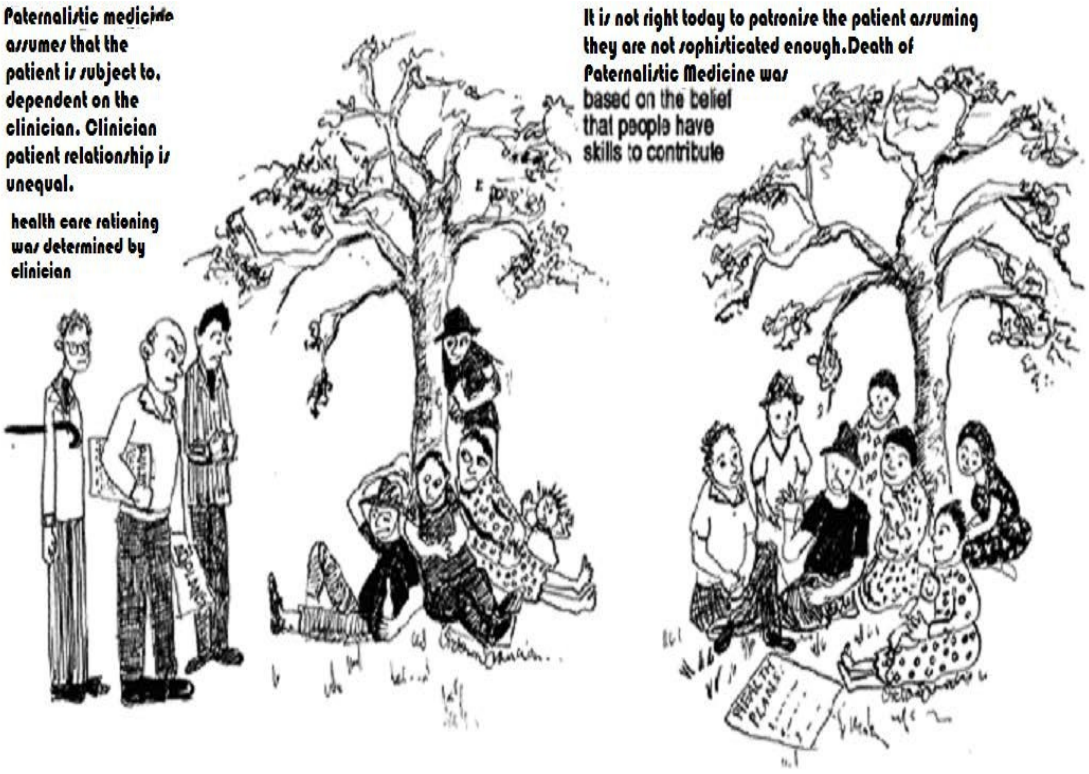
-Every encounter with a heath care provider has the potential to make a difference as to whether an individual gains maximum benefits from that health contact (Mason *et al.,* 2008). An unsatisfactory interaction may dissuade an individual from seeking help on future occasions and may reinforce perceived access barrier.

-An addition from Fuglesang (1982): When the professional is so preoccupied with his knowledge that he can see only the ignorance of others, or as this author thinks is uninformed pessimism. Platitudes are expounded in the name of professionalism. These include: child malnutrition is a disease caused by the ignorance and poverty of the mother; the mother's lack of cleanliness causes diarrhoea. Even without defining ignorance and poverty the diagnosis is considered precise and mothers are prescribed a dose of health education or a dose of nutrition lessons.

- A tendency for even more vulnerability due to some likely beliefs in fate amongst some communities. For example, despite the fact that the duration of pregnancy provides considerable time for planning and preparation, community members indicated that few people made an advanced decision or plan to deliver at a facility and that most waited until labour began to decide where the birth will take place. This was reported in in a study sponsored by Family Care International (2003) of care-seeking during pregnancy, delivery, and the postpartum period in Homa Bay and Migori counties.

One major factor that contributed to the lack of advanced planning was the unpredictability of labour. Since it was impossible to know what day or what time of day labour would begin, community members found it difficult to make any preparation. In view of the difficulty of planning for unpredictable events, many community members perceived pregnancy outcomes as predetermined by God. The study recommended that there was need for behaviour change to heighten community members' sense of self-efficacy and control over their lives.

McClanahan (2013) in a Forbes article described the opposite in: 'Death of Paternalistic Medicine'. It is not right today to patronise the patient assuming they are not sophisticated enough. Apart from that, they were now entitled to assuming obligations and a rights approach to their health. One could not expect to ride on rights without obligations, but nevertheless the onus was on health care providers to ensure this minimum threshold was met.



Paternalistic medicine (Adapted from Community Eye Health Update)

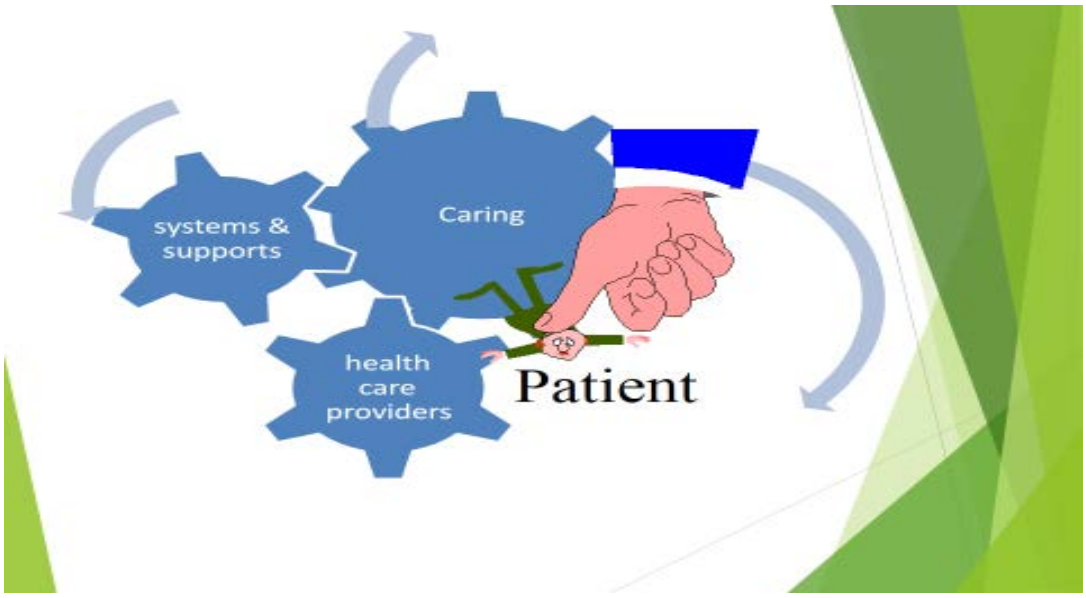


Fig: In paternalistic health care, the patient might fall through the cracks in the midst of the complicated health care system
(Courtesy of Macharia S.Kamau 2018)

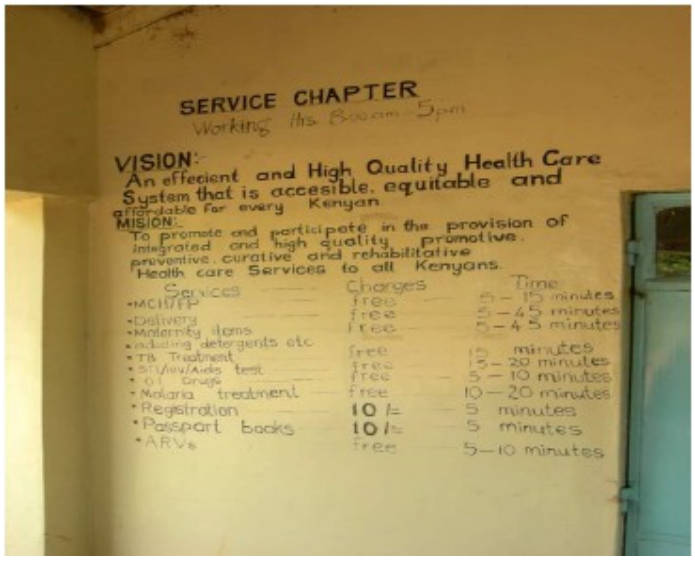
6.5.3 Construct No.3. When does quality of care become a concern to us?

Does quality only matter as and when we become consumers of the service or is it equally important when we are the service providers? What happens when we/or someone close to us becomes the consumer of the very service we either give or don't give? How can we indeed make the service charters prominently displayed in every department in our public hospitals a reality of the services we give? To discriminate against any of the clients seeking our services is against the Bill of Rights as enshrined in the Constitution of Kenya.

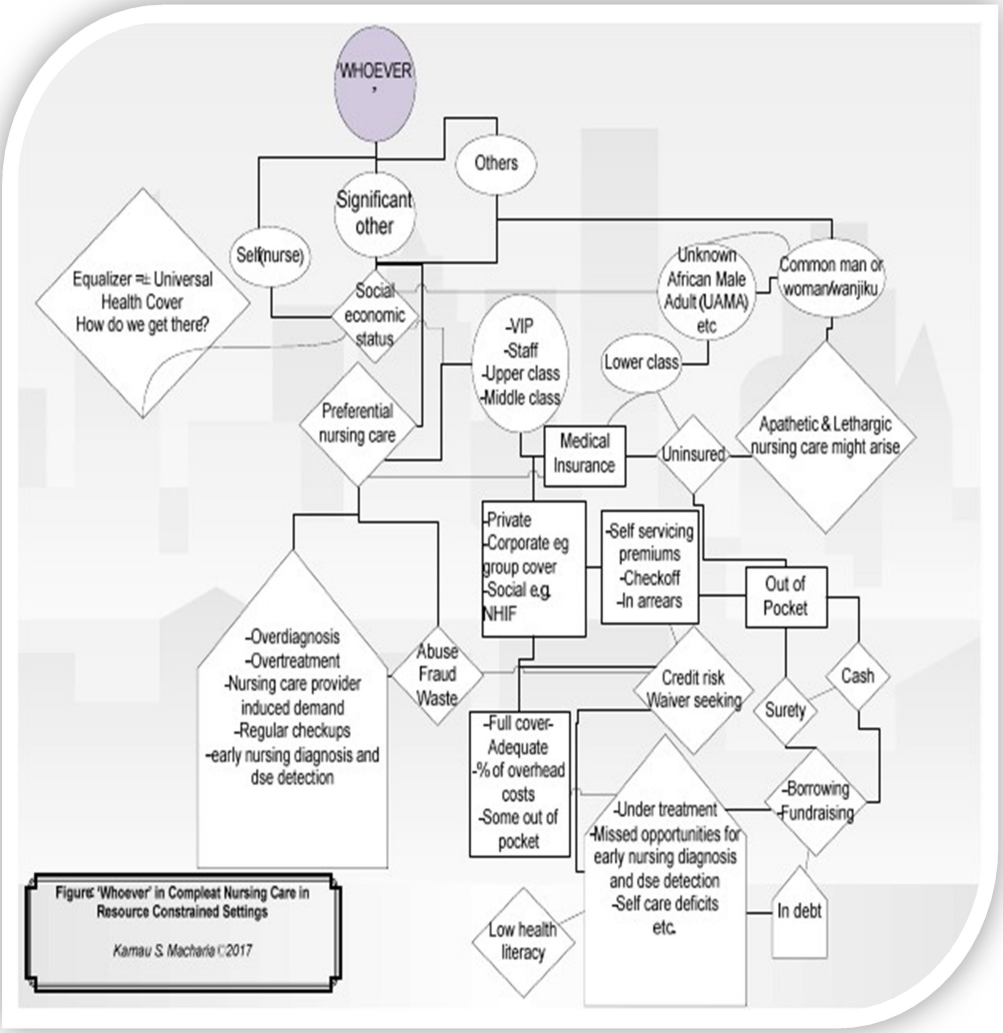
Relating this construct to oneself or family members is compelling; how would one feel if their mother, son, husband, etc. had a bad outcome that could have potentially been avoided? Why did it become necessary that the client 'knows someone or known by someone' in some health facilities in order to be assured of better, perhaps faster/better attention?

Bureaucratic accountability did not always work, and sections of the general public did not necessarily like following order, just as some staff were not always impartial. This becomes apparent when we consider 'queue jumping' by those who happen to be 'well connected'. Clients who have no acquaintance in the facility may have to wait for quite a long time to get attention, emergencies notwithstanding. So having someone on the inside, a cousin, an in law, a friend was found to be useful. This often gave rise to rampant corruption, marginalization and alienation of section of the population.

A section of staff nurses shared their misgivings at some point, *'Mdozi anaboo akiwa na mgojwa wake ana-insist apewe mpaka blanketi saa hiyo the rest wanjifunika bedsheet',* everyday Swahili dialect for - our supervisor is an interesting one, when she happened to have a patient known to her, she insisted that a blanket be made available to them whereas the rest of the patients had to made do with just a bedsheet. Someone explained 'it was just as difficult for everyone when the meagre resources could not go round everyone, so why not pamper one of your own who was in need?'



Pic: The service charter 'say what you do and do what you say you do' in a rural public health facility



A popular nurses' social network run a *'Be-the-Nurse you would want as a patient'* campaign (www.allnurses.com). An instructor in nursing school used to tell the novice student nurses, 'make the bed as if you will be the one going to sleep in it!' A slogan by the College of the Nursing *University of Colorado Denver* went like this, 'Be the nurse everyone looks up to'.

There are people who will have exceptions to this thought, but to this author, he believes it's important to understand that most staff want to do the right thing and that most people think doing the right thing is a great thing until they have to do it themselves. The issue comes around when people doing the right thing try but do not go the whole way. Because people are afraid of rocking the boat, of asking questions, to become suspicious and want to find out.

Unfortunately, if things have to change, sometimes one has to rock the boat. The sad part is sometimes the person rocking the boat falls out and is forgotten. Like in the following excerpts representing quotes of staff from an informal interview. Two different instances but with related outcomes. The first two were taken verbatim and the later paraphrased (see **The storeman & The dignitary Just a thought** below).

The dignitary

… the mother- in- law to a member of senior hospital management got admitted in one of our units, waoh! Everything in the unit changed, we were treated very well, and they even started giving tea with a snack, the status of supplies improved instantly. Of course, we also did our best to take care of this special patient; we took extra precaution in everything we did. Even the (used to) sluggish staff shone through. All these would not last for long as we went back to what we were used to as soon as the patient got discharged. [A nurse in one tertiary hospital shared].

…You see when a dignitary is visiting the hospital everything surfaces from branded linen, bed-nets, name it. The walls are scrubbed high and low. But that is as long as it lasts then everything goes back to 'normal': the usual out of order, out of stock, shortage of this or that, including staff. One time Hon. Ngilu was visiting us, we could not imagine it was the same hospital, everything had changed overnight… the wards were decongested, patients were not sharing beds any more (by the way it's no honorable task to ask the patient to leave before he is well, just as it is no joke to beg a patient so as they can share the bed with a new patient...), this was amazing, however short-lived. The VIP was supposed to see the innovations; she was going to open a new installation within the facility, which was the business of the day. Everything had to go as planned - they did not want the outspoken staff on duty, no troublemakers wanted [Hon. Charity Ngilu (now Kitui Governor) was at one time the Minister for Health in Kenya].

The Surgical Camp

It was an open secret that quite a number of public hospitals did not have adequate running water. In one such a ward there was only kitchen tap in the procedure room for the staff, none in the six cubicles and open ward. Mark you a good number of public and some mission hospitals have a real challenge dedicating some handwashing sinks for patients and staff, the same applied to washrooms. In one county hospital's labour this author was offered a sterile bottle of sterile normal saline to handwash, and the staff indicated that this happened now and then. Such an outrageous incident was not something you hear from anyone but it was happening. In infection prevention practice and control (IPPC) the clarion was '*No one* is immune, *no one* is *safe*' and 'As long as one of us was not practicing safety no one was safe'.

[Kenya Patient Safety Impact Evaluation (KePSIE,(2015) a project between MoH and World Bank showed that 98% of health facilities did not comply with safety standards, if indeed <1% of health workers washed their hands while attending to patients, yet 90% were aware of the importance of hand hygiene. According to WHO it classified hand washing as the single most factor in reducing hospital acquired infections(HAI)].

Hand sanitizers and such like necessities were the preserve of a few especially during annual surgical camps e.g. *Smile Train, Operation Smile,* O*bstetrics Fistula* and, *ear nose & throat* (*ENT)* camps etc. though not in any order or about any one hospital. Volunteer medics from other parts of the world came around. The place transformed overnight. There was plenty of snacks, air freshener, tissue rolls and germicide handwashing soap, name it. Some of the previously blocked this and that system now somehow worked, but as usual not for long. We would be back to the normal life. The unusual would be if this 'normal' did not resume for the better part of the year. We had reduced our expectations on quality for ourselves.

In the run up to some of such situations as the two above a lot of work was hurriedly done. A lot of pressure at times has been placed on contractors and health care providers to meet political deadlines or just to make some people appear to be working. This left little to imagination in terms of sustainability and quality of such work. Buildings with wet paint had been commissioned while others had collapsed days after the launch.

The sentiments above have a far-reaching interpretation in terms of not only staff attitude but also the aspect of supply of items, tools and instruments to ensure smooth running of the health

care facilities. It also shows that virtually everyone in this country might be a candidate for receiving less than adequate quality of care unless there really is a way that there could be a continuous supply of basic cross-cutting equipment and drugs as will be discussed in construct No. 4 below.

To the health care provider likewise, do you suppose that if it had been you or someone you know you would have done it differently? The ultimate measure of quality in resource-constrained setting (and I believe elsewhere) is the care one would realistically wish for themselves or their significant other(s) in the given circumstances. Who and what would happen if the who (patient or client) was not a significant other, a well to do, a very important person (VIP), a staff or just any other ordinary mwananchi? It is also the ultimate prize that we sometimes have to pay for when we falter and fall into the same (unrepaired) system that was part of us.

This is what happens when we continue to see predicaments of recipients of healthcare as if they were events done on screenplay. During the long doctors strike that lasted over 100 days (early 2017) despite faces of despair in our public hospitals appearing all over the media, one of the governors was heard on air [49] 'We are not telling doctors to go to the hospitals to get treated…' As political leaders pushed their interests to access and attain (or retain) power, some had the guts to make such irresponsible statements.

Earlier on, a panellist had wondered why some of the governors and people of means used to go for medical care out of the country for seemingly less complex ailments and whether indeed this meant they did not trust the country's health sector. But then most had a state-sponsored medical cover of between Ksh10-20 million per annum, an opportunity to luxuriously sample some of it was 'understandable' for them. The 12th parliament even put a proposal that would see the legislature's many wives and children born out of wedlock included in the comprehensive medical cover.

The editor's note on *The Conversation* on 25th August 2017 observed that health systems in the African continent would not improve unless leaders use them. 'African politicians seeking medical help abroad was shameful, and harms health care' quoting Prof. Tahiru Liedong a specialist in strategic management from University of Bath (UK), School of Management. Instead of fixing the health care systems in their countries African leaders sought medical attention abroad incurring huge costs (usually a cost borne to the tax payers). He recommended that this form of medical tourism should be banned [https://theconversationafrica.cmail19.com/]. In March 2018, a motion brought by Kwale Women Rep Zurekha Hassan sought to compel all public servants to seek for treatment in public hospitals.

An absurdity of the same was where some of the medical staff (or their significant others) for some reason could not access care in the very institution they were working. One was never one among equals even where they worked; cost may be prohibitive; or in the medical scheme care was based on seniority; one might have exhausted their cover limits; indirect costs may be out of hand; the hospital might be economising on care to its staff due to escalating non-labour costs of providing the care etc.

Health care providers on locum in some high-end facility on various occasions (including this author at some point) could not access the same care they were providing. Some resorted to over the counter self-medication. Others continued to apply themselves even though they were not in good shape healthwise while on shift in such a hospital. Apparently, this looks like negligence on both parties especially since such situations (though in the better off facilities) often involved overworked and understaffed care environments.

The other reality (a common scenario) was that the facility was relatively inferior in the eyes of the care provider such that they would be reluctant or would not be expected to seek health care there. If that ever happened it would only act as a holding ground as they await evacuation from this 'uncertain' facility to a named hospital of choice. Just before then, some special arrangements would be needed to ensure some level of 'round the clock' care, often at the expense of less fortunate patients.

The quality of care ought to become a concern to us when we consider the all too common lay care-takers (spouses, relatives, friends to the admitted patients) in Kenyan hospitals who 'volunteered' their time and effort, kind of taking over the health care povider's' role. It had been observed that in some instances they were doing 'total nursing care' inside some public hospitals, this could mean many things. What standard of care do lay care-takers give? Were they somehow filling up for the shortage of staff in some of our public hospitals? This practice had also tended to have a gender bias component as it engaged the women's time more than the men.

While direct treatment costs are a major concern for the family and service providers, it is very important to know that there are indirect costs borne by the service users and their families. The concept of 'time is money' has sharp realities for people living in resource-constrained settings. Seeking treatment and caretaking for the sick one in hospital involves leaving day-to-day responsibilities.

In existence of 'work today, eat today' costs are multiplied when other family members are involved either to fulfill roles as cares or to accompany the patient for certain procedures *(Barriers to cataract surgery,* 2014). The Kenya Health Facility Survey of 1994 acknowledged the caretaker issue. This is a call for further study. The topic on lay care givers and home care has been covered in Chapter 14 of this book.

[49] NTV Live; *Sidebar*, 8th March 2017 18:30Hrs, on location Naivasha

6.5.4 Construct No.4. Is there really a way that there could be a continuous supply of basic cross-cutting equipment and drugs?

How can we equitably distribute the scarce resources? Which formula would work? Rationing and triage decisions about finite resource allocation are a central part of the decision-making process in the Kenyan health care system thus raising ethical dilemmas. But more important it is about access and utilization of that health care. The truth of the matter is that healthcare is a resource or a product that an individual consumes in which all or part of the cost should be their responsibility. But does one have a right to healthcare if they cannot pay for it?

Possibly the perspective we need to look at is what can we do with the available resources versus how can we make the resource endless. We may want to do so many different things but the bottom line is we only have so much money. That is a hard reality but it is something we all have to live by. I have *(X)* amount of shillings and I need to figure out how to best apportion it.

If the solution was simple or straightforward we would not be having this argument or have any need to write a book like this one. If this wasn't an enormous ethical, moral, complicated dilemma no doubt we would already have solved the problem. Even WHO (2016) recently released a *Tool for Situational Analysis to Assess Emergency and Essential Surgical Care* to assess the gaps in the availability of Emergency and Essential Surgical Care (EESC) at resource-constrained health facilities.

However, i*f we could create a work environment where the little we have is valued and handled with care and respect we could achieve a lot* (CHAK, 2013). The Kenya Health Policy Framework 2012-2030 section 5.2.6 Policy Orientation 6 refers to Universal access to essential health products and technologies would ensure that effective, safe, good quality, and affordable health products and technologies were available and rationally used at all times. Nelson William (2009, p166) underscored this in his *'Handbook for Rural Health Care Ethics*': Allocation of scarce resources is a reality for health care professionals and organizations.

Resource allocation issues can be particularly challenging for rural communities, where resources are not enough to meet all needs and fewer alternatives exist to resolve conflicts between competing needs. Though resource allocation issues are economic in nature, they inherently raise issues relating to organizational mission and ethics.

Might I recommend this handbook above together with another one; 'Guide to Quality Health Care' that was referred to earlier on (AHRQ, 2005). These would be great resources to the Kenyan health care providers and consumers as they contain guidelines on scarce resource allocation and consumer education. Bukachi *et al.,* (2014) did some good work in Malindi Kenya on health care priority setting highlighting a framework on *accountability for reasonableness* (A4R).

One subscriber posted his dream on Kenya National Union of Nurses (KNUN) wall pertaining to some less than desirable status of supplies of emergency and resuscitation equipment on Facebook on 27th May 2014 (see **The dream** below and **Shot and left for dead** in Chapter 2). This author kept tab on the trending:

The Dream

I have a dream that one day in every patient's bed there is a plugged oxygen flow-

meter, pulse oximeter, defibrillator, ambubag, BP machine, emergency oxygen cylinder, suction machine, nebulizing machine, suction catheters proper bed with wheels, branulas, high concentrated oxygen mask, two nurses per patient, standby emergency bell, add more. Ladies and gentlemen, who have such a dream? This will avoid the fact that instead of rushing to save a patient, you rush to borrow the items! That piece of equipment you have been asking for and when you need it most it seems to always be kidnaped. In use! This is the thought I live with… Lupita Nyong'o an Oscar Award winning actress said - *...all dreams are valid no matter who or where one comes from...*

This author does share such a dream, may be loftier- (emphasis mine). I say dream Big because all dreams are free. Another wise person added that "I dream. I test my dreams against my beliefs. I dare to take risks. And I execute my vision to make those dreams come true." Let us all dream the Kenya, the health system we want.

6.5.5 Construct No.5. How much are we prepared to put in to make sure quality care occurs in every health care setting?

How would we transform the environment and base practice on the best-informed evidence? Linking evidence to action as was referred to by Rycroft-Malone & Bucknall (2010). What level of quality are we willing to fund to get consistently good outcomes?

According to a rss-baseline–assessment.pdf report (2013), which studied the functionality of Kenya's health referral system, 'many people have the perception that lower levels in the health care system provide lower quality care; therefore, they seek care at higher levels in the system, where specialists are concentrated. This preference for higher levels of care, even for simpler ailments, is not cost effective. In addition, a shortage of health workers across the health care system, especially at lower levels, lends credence to the client preference for higher, rather than lower, levels of care'.

The report recommended that there ought to be a close relationships between all levels of care and ensure that clients receive the best possible care though rational use of health services and provide equitable specialized services to the populations that need it. There should be adequate linkages and continuum if and when referral became necessary.

Really why should some health care facilities, sometimes within the same region (or units/wards within the same facility) have varying (at times two extremes) standards of health care delivery? It is good to complement government efforts towards quality health care by coming up with viable income generating projects. It is with this in mind that nearly all public hospitals in Kenya have a parallel policy for allocation between their income generating units (IGUs) and the general side.

However, the disparity could at times raise several moral questions. The argument had been that it's the IGUs that supported the general side of the hospital. It was possible to convince an observer to buy-in either side of the argument. However, in the unlikely event that it was the general side that supported the private wing, we might appreciate several fundamental truths. Weighing the initial capital outlay in terms of major installations and staff that the IGU's preferentially accessed by virtual of their affiliation to the general hospital (such as O_2 plants, diagnostic laboratories, laundry, imaging equipment, staff, super-specialty technologies etc.). (See **class discussion** in chapter 2).

The health care workers need to be take control, develop strategic alternatives, be empowered to bringing their influence on resource allocation to bear on creating work and care environments that are safe, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people–including patients, their families and health care workers themselves.

The sense of empowerment means to be in a position to contribute ideas and make decisions that affect their units, as well as the ability to take ownership of those achievements. One big step comes in allowing people to identify alternatives. Group members brainstorm to generate many possible solutions, maximizing the likelihood that a good solution is ultimately chosen.

Brainstorming session requires group members to come up with as many solutions as possible while following the following rules: don't evaluate ideas; don't clarify ideas; encourage zany ideas; expand on others' ideas; record all ideas with no reference as to who contributed; and encourage participation from everyone (Putnam & Paulus, 2009).

They will then evaluate and select by comparing these ideas, their pros and cons to see which best meets their set goal (what the ideal solution would 'look like') that they had arrived at earlier at problem analysis: through a realistic look at the nature, extent and likely causes of the problem at hand. This could be a problem they themselves identified in their unit that they wanted/needed to be fixed. What kept them awake at night?

What can we fix? The pattern suggests that analysis of the problem happens first but the group then cycles back and forth between goal setting and identifying alternatives, research showed that the logical order that these are completed does not matter as long as the functions are completed. The chosen path will revisit and consider the rules and resources available to them (Hirokawa, 1994).

This way, employees commitment, motivation, and loyalties could be increased, employee turnover reduced and satisfaction increased in the organizational context. Gass and Seiter (2003, p.69) quoted some employees saying, "once we've invested our time and energy or poured our hearts into a cause, a person, an idea, a project, or a group we find it too difficult to let go". They knew (whether they were conscious of it or not) that they created the structure and they can produce and reproduce it, and that they are also constrained by it, by the decisions they made.

These were the propositions of Structuration Theory of social interaction (Giddens, 1979). Unfortunately, health care providers may not always be aware of such structures, or be aware of their ability to change structures

Section 5.1.1 of Kenya Health Policy Framework 2012-2030 addresses equity in distribution of health services and interventions which aim to ensure that there is no exclusion and social disparities in the provision of health care services. Services shall be provided equitably to all individuals in a community irrespective of their gender, age, caste, colour, geographical location and socio-economic status.

The focus was on inclusiveness, non-discrimination, social accountability, and gender equality. While section 5.1.2 deals with people-centred approach to health and health interventions aimed to ensure that health care services and health interventions are premised on people's legitimate needs and expectations. This necessitates community involvement and participation in deciding, implementing and monitoring of interventions.

The need exists to align quality at every level to make sure that all levels of the tier system somehow relate to each other in terms of supplies to enable them to function optimally. What needs strengthening? It should be possible to optimize care at all levels. Adequately resource health facilities according to the National Health Service Standards. To achieve high-quality care for every person, every time, we need to work across the whole range of healthcare to make sure that all levels of the system relate to each other in supporting quality (CHAK, 2013).

Effective systems to regulate, measure and improve patient safety were important in evidence based decision making. There was a need for inspections and other forms of accountability

mechanisms. So were monitoring mechanisms and punitive tools, compliance with standards and administrative requirements etc.

Through an ongoing a World Bank/International Financing Corporation (IFC) project, 4 medical workers from each county were trained as facilities joint inspectors in 2016/17. Increases in inspections had been shown to lead to improvements in the patient safety standards and quality health care provided by health care facilities Kenya Patient Safety Impact Evaluation (KePSIE) World Bank (2015). For example, the facility supervision visit had for long been shown to be one source of drugs and other consumables by withdrawing excesses, almost expiring, misplaced supplies from dispensaries within its catchments.

While doing this health care facility supervisors should be fair, respectful and supportive. However, anecdotal evidence indicated that supervision (pre and post-devolution era) was related to whether or not there was a partner/donor, a funded study in the picture or else it was not done as such.

EngenderHealth's *Client-Oriented, Provider-Efficient model* (COPE®) was a simple process for improving quality in health services by encouraging and enabling clinicians and other facility staff to assess the services they provide jointly with their supervisors. Use of COPE in Kenya and Guinea, for instance, led to improved immunization services as well as enhanced health worker performance and better attitudes toward supervision (available:www.engenderhealth.org).

We ask the same question again - How much are we prepared to put in to make sure quality care occurs in every health care setting? In Kenya and possibly in other low-income countries, whether we liked it or not it's the political leaders and their organizations that set the agenda for the 'big picture' of priorities and approaches.

Ideas and values were mobilized to support political objectives and to build coalitions of support with the next election in mind. *There is an angle to every other thing they do, and that is why one gets into politics,* observed one political analyst. The images they create with this approach were theirs to use however they like.

Politicians would do anything and everything including playing with the lives of people as long as they achieved their political objectives, instead of asking what it was they could do to improve the socioeconomic lives of their people. For them, quality health care is just another word going round without coming into terms with what it takes. The reality was that it had to be cultivated and nurtured. Unfortunately, this fell short of what the citizens can realize for themselves in terms of health care. Yet it still has a direct bearing on the health sector.

A good number of issues we had pursued as a country were normally a function of 'good' politics rather than good policy or could be a good number of them were *misleaders* and not good leaders. Accountability assumes that the leader accepts full responsibility of that which occurs under the auspices of his or her leadership.

Rarely were leaders and planners challenged outside of the political electioneering season. Seldom were they held accountable for failed plans. It should not matter whether someone else "did the deed"; it only matters that the leader claims accountability for the actions of commission or omission of those for whom he or she holds leadership responsibility.

Even when there were allegations in the area of accountability, leaders were not willing to participate in a social audit or debate, to subject themselves and explain to the people their evidence in the court of public opinion (See **Plague for profit** in Chapter 3).

Medical staffs were not supposed to take sides in politics. Political neutrality was necessary to

ensure patients were kept from harm's way. But politics in the public service was becoming palpable especially with the numerous industrial disputes; it was difficult to ensure staffs were working without interruption of service provision.

Following the 100 plus long doctors' strike in early 2017, clinical officers were agitating to have their union registered and ensure their members got entitled to health service allowances like the doctors and nurses. An *official* was being interviewed in the media[50] observed that the political class were not in touch with what went on in public hospitals, why – because they did not seek for health care there. He suggested that a law should be passed to compel them and other civil servants to go for health care in public health facilities.

It was likely that the typical Kenyan politician is also a reflection of the brand of leaders who made it into both professional and regulatory bodies. Just like in the political landscape a section of those in unions, professional and regulatory bodies could be described as crafty and in principle opportunistic. Others manipulated others to get into power or to remain there. Incidentally, when misfits of any profession become its point men/women, many sectors including quality of health care might suffer.

Trade unions representatives had in their wisdom endorsed their preference for a particular candidate in the election divide. It was unfortunate that this could happen infact holding trade unions' leaders at ransom by political players instead of encouraging competitive bargaining was morally wrong. Sources indicated that it was to this extent the government read 'sinister' motives in the strikes.

It perceived the strikes to be part of the wider conspiracy to paralyze major sectors – education, health etc. with the hope that citizens would get disillusioned and resort to mass action, a revolution sort of. This was compounded by the repeated presidential elections (60 days in between) as each union leader intended to deliver on their block. Fortunately (or may be unfortunately) some union leaders managed to make it to the 12th parliament, some as nominated MPs. Whether these reservations were unfounded or not, why government had shown such indifference or perceived neglect of the workers grievances was a worrying precedence. Whether this was so or not, the fact remained that a good number of trade union leaders were singing the songs of the politicians.

While it was important to catapult as many health care providers into elected political positions, the same should not be abused. It was not unusual to fundraise for their campaign (KNUN memo to members dated 19th July 2017). This was memorable coming in the height of national nurses' strike which had entered the 40 plus day. Sections of the fraternity expressed their misgivings. Let's consider the following post on social media: '… using the plight of nurses to advance partisan political interests instead of subscribing to professionalism and rule of law…'- (Posted in July 2017 Face book wall *Think Tank for Nurses Café*).

Fortunately or not some of these characters tended to find their way into elected or appointed positions in the county government etc. For some strange reasons they seemed to get away with the mess, they had created (including rot and mayhem). It was naive and very short term to assume that divisive and partisan politics would enable us to solve what clearly were big problems in nursing and by extension the country's health sector.

Hon Ole Kaparo the chair of National Cohesion and Integration Commission (NCIC) expressed his frustrations by saying, *'nyinyi mnachagua wakolofi halafu mnatuabia sisi tuhakikishe hao wakolofi hawatawasubua'*, paraphrased from Kiswahili *citizens elect misfits and expect the commission to rein on them not to cause trouble, it's a tall order.*

50 Radio Citizen, *Jambo Kenya*, 14th March 2017, 8:00 Hrs

Similar sentiments were echoed by Prof PLO Lumumba's public address in Ghana *Africa is dying because we elect…* From the foregoing many African regimes did not focus on the well-being of populations, instead, they impoverished their citizens, denied their enjoyment of basic human rights, and eroded public health. Video available on *YouTube*: https://www.youtube.com/watch?v=v9Dm2Xb79g, www.ghanabusinessnews.com

But we have to remain hopeful and more importantly shift from the culture of over-relying on political leaders on matters of policy and legislation, as politicians had made us to believe they were able to do everything for us (including reading the constitution on *our* behalf in the countdown to referendum of 2010).

It was essential that the health professions contribute to the decision-making and implementation of any health service reform. Therefore, we need to have this at the back of our minds as a necessary evil even as we write to a Member of County Assembly (MCA), Chief Officer, Governor, Senator, Legislator (Please see a sample letter to county government Appendix X).

Bukachi et al., (2014) interviewed a local politician and this is an excerpt of the quote (see also **essay: Why were there no medicines in Kenyan hospitals if there was so much else to show off?** in Chapter 3 and **Ambitious agenda b**elow).

> ***Ambitious agenda***
> *'We politicians also sometimes play a big part in relevance because without guiding your people, you may set up a facility somewhere which is not relevant. We have had a place in this municipal council whereby the councillor constructs a market, but you find that the population is very small and that facility will not serve because they don't have things to sell in the market. So we are putting a facility where they don't need one … and somewhere else, that facility is needed and maybe the council would have gotten some revenue.*
>
> *'So relevance is important but sometimes we don't put this into consideration when we are setting priorities. We get into political ambition'. Some politicians and former leaders at times work for the downfall of programs and projects by the incumbent. It was like the saying goes 'as long as I am not inside the house I will shake it until it falls', it did not matter what benefits would otherwise have been accrued to the community.*
>
> *It was felt that oftentimes some projects were done hurriedly while others acted as conduits for glory or for pilfering public resources but not for the benefit of health care.*
>
> ***Buying buy-ins:***
>
> *In the traditional African context, leaders often had to make do with ambiguity from their constituents. For example one leader after explaining an elaborate blueprint to his rural constituents on what needed to be done to uplift their health care standard, the feedback he got was beyond belief, 'That's enough speech for today, now talk to us'. There were other reasons for that including miscommunication:*
>
> *This could mean many things: further consultation was needed, the language was complex etc. There was the easy interpretation at such a point the path that many of today's leaders opted for: the electorate wanted some hand out in order to buy in to the proposal. Many well intentioned proposals might have stalled from that moment.*

It had become more necessary that as professionals we must attend political rallies, spin, jostle for elected positions, cast our votes and take a stand on key issues. Agitate for resources by; participatory budgeting, advising on feasibility, negotiating for memorandums of understanding (MoU's) to commit elected leaders at county and national levels, holding them accountable for making sure that quality health care occurs in every health care setting. The ordinary residents were used to being blinded through various forms of tokenism and bare minimum interventions rather than marshal plans that would uplift their social economic status.

5 Great Questions to Ask When You're a Leader:
Great leaders don't just tell people what to do- they ask questions. In addition to asking questions to support your work as a nurse leader, the nursing staff will appreciate the leader who elicits feedback and acts on it.Who knows you may hear an innovative solution that you had not yet thought of.
1. What strengths? -strengths of each team member, areas is the group doing well in, assets can you leverage, strengths does the organization. Focusing on what is working encourages the team.
2. What kind of leader? -Asking your teams- those below, around, and above you- for feedback on your work style and skills, to help you grow. Since you asked for it they will open up!
3. How can we do something different?
4. What does the ideal look like?
5. How can I help you? Modified from 5 Great Questions to Ask When You're A Nurse Leader *http://artofnursing.com/5- great-questions-ask-youre-nurse-leader/*

Put elected leaders in the picture about group efforts (e.g. labour issues, evidence, research findings etc.) why? Because they were unlikely to notice. Why? For a lot of these leaders, they thought that working meant heading out to the work area to "show the flag," and do "a meet-and-greet the people", "speak to the choir", "meet the team members working". While instead, they were just walking around. An example is when they shamelessless flag off truckloads of condoms and unnecessary clutter to the public hospital as the public cheered on the 'drugs'.

Oftentimes the leaders were made to believe that people were impressed with what they were doing, while actually it was quite inappropriate and the only people responding were their fan-base who were cheering them on. What with the red carpet, mobile toilet, and throne like chairs!

Instead of the leaders wanting to appear big to their constituents at the expense of the workers, they ought to PDCA (Plan-Do-Check-Act) or what was referred to as a Gemba walk in leadership for change. Gemba is a Japanese term that roughly translates to "A place where actual work is done" or what they say in manufacturing where value is created for the customer," Compton (*n.d*) Emeritus Professor Rochester Institute of Technology.

Gemba is the process of go see, ask why, and show respect. Carefully observing to see where things are not as they should be. Sometimes there is less walking involved and more of just standing and watching. Get a feel for what is happening. More importantly, try to envision what *is supposed to be happening, become totally conscious of what is really happening*. Check on the *health of the systems* by looking at how people and processes engage.

This way they might discover there was someone downstream likely coping with an issue that he should be raising (Or worse, there was no process for raising the issue, or worse still, no process to respond if they do). On the minimum, such an encounter should focus in on one of them.

The same question - how much are we prepared to put in to make sure quality care occurs in every health care setting? Health care workers ought to seize the opportunity and advocate in an effective manner for what was truly best for themselves and their patients, advised Mike Mutungi in *Kenya Mpya* (2011). Health is a highly professionalized service but the health care professionals lost a golden opportunity in the constitutional making process that took almost seven years.

Many people now believe they would have easily argued for a Health Service Commission and the merging of all laws on health care into one chapter but generally the medical fraternity was underrepresented and largely not bothered with the constitutional making process. Apparently, decisions that continued to affect them today and into the future were made largely in their absence. Only to resort to activism after the constitution had been passed. The few present had expressed misgivings and felt the draft was hurriedly discussed - to date their fears had not been vindicated.

There was hope that the Health Bill 2015 (Health Act 2017) would harmonize the services and make the best to salvage the health sector. Pronounce itself on human resources matters (distribution, emolument, promotion, training, CBA's etc.)

These seemed to be the elephant in the house in as far as devolution of health services at county and national level were concerned. The act would also address matters capacity, roles of directors of health, costing issues, advisory role on standards & guidelines commodity, create transparency and equitable distribution of resources, meticulously unbundle the functions of the two levels of government, bring together the over 20 regulatory bodies under one roof.

On the other hand *Footsteps* 93 (2014 p 8-9) advised on making the most of the meetings with decision-makers such as: *Think who you will meet with; Plan who will attend the meeting with you; Arrange the meeting; Plan how to present your requests at the meeting; Introductions; Logistics; Keeping on track; After the meeting.* We need to sign a performance contract with elected leaders and agree on clear targets and deliverables (on health care in the County) and then hold them accountable to those guidelines. Sometimes this might call for some form of a campaign strategy.

At the back of the mind recognize that the ultimate decision maker is the person who has the power to give you what you want – the person who can say yes or no to your objective. That means learning to pick your battles wisely. You cannot spitfire and expect much else in return, it is a question of communication and strategizing, there was a lot to learn in the area of campaigning for health care workers.

For example, learning a few tips: Who are the people who can move your decision maker(s) and help you achieve your objective? Is it the media? With the advent of digital migration in 2013, over 100 TV stations were on air, giving Kenyans a cocktail to choose from. The media was however not the target audience but a channel.

Media was generally a means to an end, media to help build support for the campaign and promote you work; The "general public" is not a target audience; The target audience is likely smaller than you think; The number of people needed to make change is not necessarily "as many as possible; The people other people look to when forming their opinions can often be a good target; Select audiences that are willing to publicly show their support and in turn attract others to your issue (Future of Nursing Campaign for Action website).

This would mean a high level of personal integrity based on zero-tolerance policies that reduce to an absolute minimum fraud, waste, and abuse (FAW) of public resources. Using what we have at hand to do more. Dealing decisively and following through until effective solutions have been realized on perennial nuisances like: out of order; out of use; out of stock through timeliness, forecasting, orderliness and punctuality (KQMH).

There was a growing imperative in modern day Kenya to scale up key health interventions (especially commodity support) to meet various international conventions, the ruling party manifestos, the constitution, Vision 2030 etc. However, it had been observed that simply scaling up interventions in weak health systems that delivered poor- quality services was likely to waste precious resources and fail to show the anticipated improvements in health (Rowe *et al.,* 2005).

According to Luoma *et al.,* (2010), there were no accurate records of inventory loss resulting from expiries, damage, quality issues, and obsolescence. Some news come sometimes of, 'Gone to Waste: Drugs worth Ksh189m meant for then New Othaya Level 4 Hospital expired in Nyeri'. In what amounted to tax payers' money going down the drain, part of a consignment of drugs and pharmaceutical equipment purchased for the new Othaya Level Four hospital has expired.

The drugs and non-pharmaceutical equipment bought at a cost of Ksh 169 million was being kept at the Othaya Constituency Development Hall in Othaya town under tight security since construction of the hospital had not been completed by January 2015.[51]

The aim of construct No.5 is to emphasize the role of the health care workers as champions at the operational and policy-making levels, encourage them not to look for excuses or who to blame but focus on finding solutions and achieving desirable outcomes. Florence Nightingale the founder of modern nursing never gave or received excuses for not performing well.

According to Anquillano-Carsola, & Castro-Palaganas (2017) 'The goal of nursing remains a Nightingale's pledge and an endeavor amidst nurses' constant battle between motivations and challenges'. Remembering that *It's easier to do the job than to explain why you did not do it* ('Forbes quote' Sept 16th, 2015). As colleagues and each other's keeper, we can demand performance in a very palatable way from each other. Impress on each other that there was a service that we must offer and that is expected of us (Kamau *et al*., 2015).

Health care workers need to understand some of the basics of the need for good information in making decisions; to be better prepared and more adept at translating their observations of problems at the bedside into an effective improvement effort. Turn quality data for your hospital into solutions you can use. Data are all around them and they are using data for clinical decisions. Every patient's characteristics and experiences were secure data to learn from.

This data continuously gathered as a routine should immediately (working backward) or ultimately be available to support health-related decisions, continuous improvement etc. For a learning organization, this becomes part of its culture though at different scales for each organization. This behaviour was in many ways fundamentally different from systems from those operating on a smaller scale to the ultra–large scale.

Policy makers at all levels (professional, organizational, County, National) have become sophisticated and will be looking for evidence to inform their plans and decisions. Evidence must be of high quality, applicable, acceptable to the users, and informing different aspects of decision-making. There was need for health care providers to understand how to use this data towards evidence-based practice by developing an intuitive grasp of situations and quick targeting of problem areas. Be on look out for a window of opportunity in order to translate the evidence to influence health care policies. Be ready to push for political support for their policy initiative.

According to Kingdon's (2003) model of policy development (a) an important problem must be recognized (b) a viable solution must be proposed, and (c) solution must have political support. Nursing research, evidence-based findings becomes a catalyst for these three prerequisites.

There was, therefore, no length we should not be prepared to go, no effort we cannot be willing to put in to make sure quality care occurs in every health care setting in Kenya. Symptomatic reactions that did not cure deep-seated issues that plague the health sector had been tried many times. The few outlined above might as well be symptomatic, thereby a scratch on the surface of this tall order. If each of us did something we might get to the root cause.

6.5.6 Construct No.6. Bridging these gaps is about assuring access to quality care 'Best Care Anywhere'

'Best Care Anywhere' as a Model for Health-Care Reform was described by Philip Longman (2010). It is an amazing story of the turnaround of the Department of Veterans Affairs health-care system from a dysfunctional, scandal-prone bureaucracy into the benchmark for high-quality medicine in the United States.

Why best? This is in the context of making the best of a situation, gaining the limited advantage even of an unsatisfactory situation. Or rather most appropriate, well advised, evidence that in the given circumstance(s) what was most sensible. What might be considered normal conditions in that setting? With the interests of the client at heart what could be the desirable end. That which is not second class service that setting but an 'on the house' treat as they say in the hospitality industry. Common sense might not allow such a criterion as best care in resource-limited setting.

Anywhere and *everywhere* can be used synonymously though this construct preferred anywhere over everywhere:-

Any-where to mean any for whichever you choose, one or some, in some degree, a significant amount. Where for at or in what or which place or position or circumstance, to what place, in what respect in respect to Best Care Anywhere.

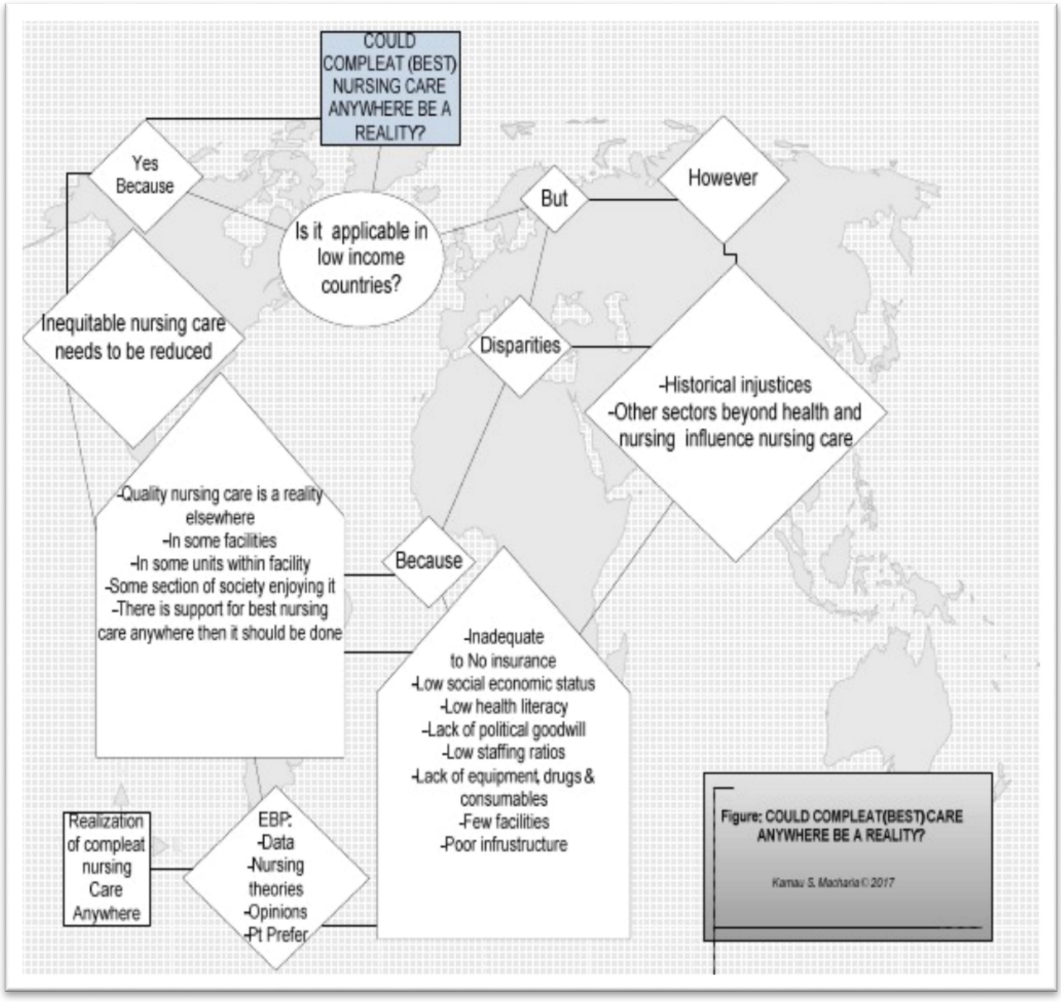
Anywhere to mean: in all places; all over; all over the place; far and wide when we refer to Best Care Anywhere.

Anyplace; wherever; someplace; somewhere while referring to Best Care Anywhere. *(Source: compilation from various dictionaries, thesaurus, and wiktionary).*



Pic: Some of the common realities of actualizing Best Health Care Anywhere in resource-constrained settings

[51]NTV live, 21HRS, 18th Jan 2015 http://ntv.nation.co.ke/news2/topheadlines/gone-to-waste-drugs-worth-



We will need to revisit some of the concepts that had been mentioned in Chapter 1 since the rest of the book has been a build up towards introducing this framework like health care professional, compleat healthcare provider; resource constrained/limited setting, service delivery quality care, health outcomes and access among others below:

Health care professional: Includes any person who has obtained health professional qualifications and licensed by the relevant regulatory body;

The Compleat Healthcare Provider: This framework envisages a compleat healthcare provider or a compleat team of health care providers. The Merriam-Webster Dictionary defines *compleat* as having all necessary or desired elements or skills. Synonyms include: accomplished, ace, adept, proficient, complete, consummate, educated, experienced, expert, good, great, master, masterful, practiced(also practiced), professional, skilled, versed (Merriam–Webster m-w.com).

It is important to put it from the outset that perfectionism is not the point here – no project, situation or decision is ever perfect and so no one is. Idealists and perfectionist is a farfetched description even of this author, therefore, to expect it of someone else would be unrealistic. Nevertheless, we should not stop dreaming of an ideal situation or person.

A compleat worker is a gracious professional with a spirit that encourages doing high-quality, well-informed work in a manner that leaves everyone feeling valued. Doing their best work while treating others with respect and kindness. However, the team and not the individual worker is considered the basic unit in the workplace in healthcare (Porter-O'Grady & Malloch, 2015). 'It is the little things citizens do that will make the difference…' (2004 Nobel Peace Prize Laureate, The late Prof Wangari Maathai 1940 –2011).

The compleat health care provider for intents and purposes of this book and beyond, it is assumed that he/she will be receptive and be transformed by the constructs of this framework and be in a position to utilize it in enhancing access to quality health care in resource-poor settings. Someone who can change some facts: like the notion that quality care is not possible in resource-constrained settings.

The point of service drives approximately 90% of the decision making in a healthy and effective system, and therefore most of the decisions should be made by the workers located there (Porter-O'Grady & Malloch, 2015). Abrams (2005) cautioned on the implication of pushing the agenda of health care systems without taking due consideration to the health care providers at the operational level/point of service, "Bureaucratic health care systems, diminishing budgets, and burgeoning paperwork all alienate us in some measure from the purposes and products of our labours. There were days when these conspired to deflate even the hardiest of good spirits".

It is not heroes we are looking for in a compleat health care provider, not just someone who can make critical decisions quickly, but one able to apply good problem-solving methods and mechanisms. In promoting the principle of subsidiarity, some decisions can be made at the lowest level as this builds confidence. Subsidiarity principle implies that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level [Oxford dictionary].

The compleat staff is not one with a 'fire fighting' mentality. People who do not approach problems proactively acquire a fire fighting mindset. Waiting for problems to manifest means being a day late and money short - by the time the problems are addressed, most of the damage has been done and will require nothing short of a hero to unravel. According to Porter-O'Grady & Malloch (2015), heroes make poor citizens and require a great deal of ego feeding. They were not necessarily good models except in war and can cause more problems than they are trying to solve.

Instead, the compleat care provider is someone who can act in situations that are ambiguous, underdetermined, unexpected or markedly different from their preconceptions. One who has an intuition to anticipate crisis, risks, and vulnerabilities that may affect the organization, the employees, and their clients. Being committed to resolving problems is not nearly as important as being committed to using problem-solving techniques and processes. Why this author was convinced that compleat care providers exist and were not a rare breed. The following observations were made by facilitators in what might be a forum attended by Kenyan *compleat* health care providers.

"The challenge facing our health care system is not the lack of demand but the demand for quality and affordable healthcare", "I am convinced that it is possible to provide quality and cost-effective health care in a thoroughly professional but personalized way", "One thing that I'm not hearing people say is, 'I can't do it,'". "Instead, the discussions I'm hearing are focused on how

we can become better at what we do as professionals and in collaboration with others to make a difference in their area". Infact, passion is leading one to say 'If I don't do it nobody else will do it'.

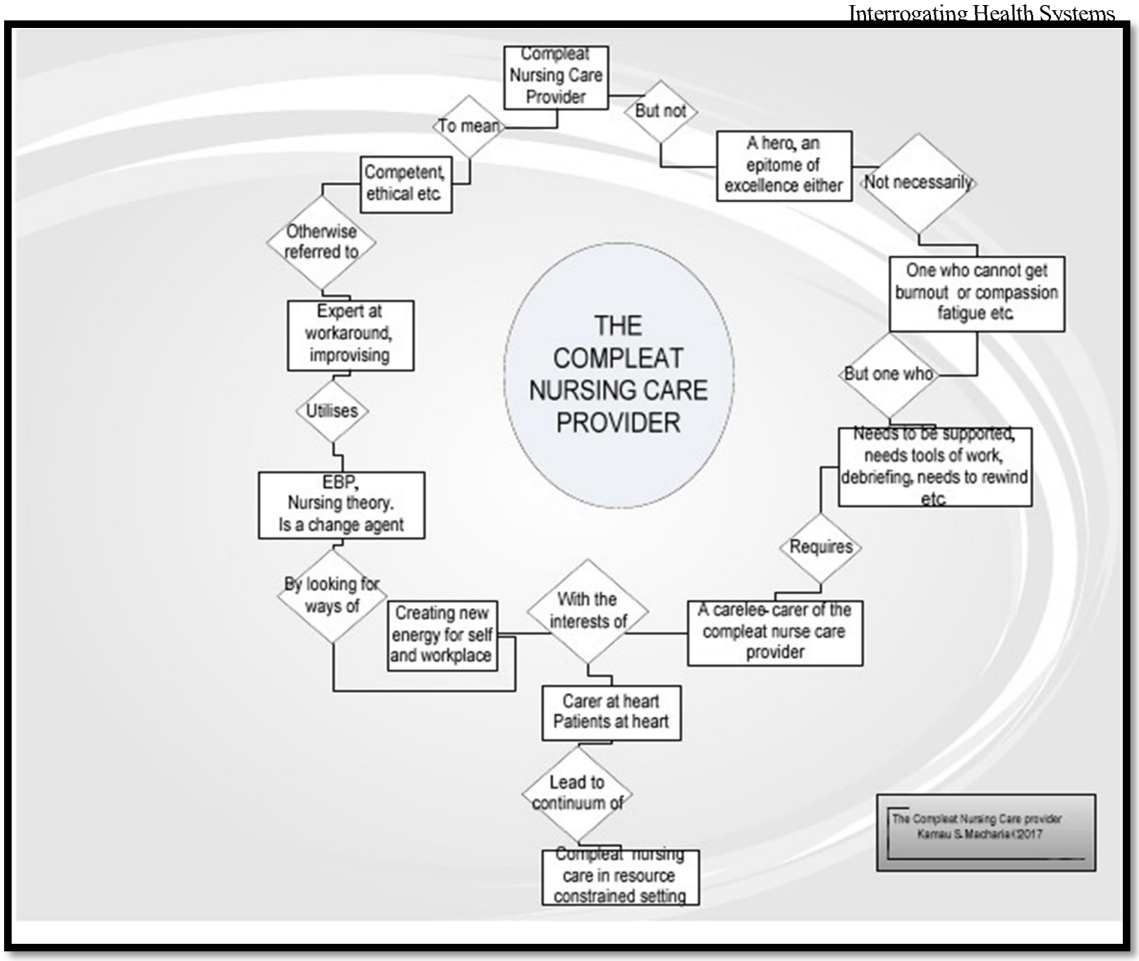
The staff in the above forum understood the contribution they made. They were willing to look at ways to maximize resources and processes to improve value for patients, payers, communities they served, and the organization as a whole.

The compleat nurse might be patterned like a Caritas nurse [high scoring nurses on the patient Caring Factors Surveys (CFS) survey] who will provide an opportunity to understand and refine the work environment and processes to further promote caring and healing (Persky, Nelson, Brent & Watson, 2008). A worker with an attitude of continuously asking "what else can I do to rise above my circumstances, and achieve the results I desire?" This is not to say we expect a perfect worker but to honour excellence, there was no perfect present to sustain.

It has been said that fear of failure or retribution that employees feel causes them to essentially "retire on the job" –who focus on noncore activities at the expense of the organization, people who expect to be rewarded for simply showing up. Further that 'expecting perfection eliminates the possibility of excellence' (Porter O'Grady & Malloch, 2015). With this, an important organizational dynamic emerges when leaders acknowledge that being right all the time is not even a possibility.



Pic:Writing a future-now health system in contrast to a congested 'market-like' post-natal unit (courtesy of anonymous photographer)



Resource-limited Settings: There are various approaches of looking at the concept of resource- limited settings but generally the terms *resource limited, resource constrained or resource poor settings* are used interchangeably. The first impression usually refers to some health care facilities in the rural parts of Kenya or elsewhere, some of which are run by the Ministry of Health or faith-based organizations.

But it could also mean certain areas within the same hospital that did not receive adequate supplies of consumables, medications, and equipment. Inefficient processes might lead to a lot of time and effort being spent looking for supplies by non-procurement staff like nurses creating a turbulence that distracted them from their primary role of patient cares.

In any case world over, there is a split of the purchaser as provider and in Kenya, we cannot ignore this necessary split. By focusing entirely on purchasing health services, rather than actually delivering them, the purchasing agency can develop contracts with health services providers which specify the services to be delivered. This also provides some form of autonomy, oversight upon each other and it also spreads the financial risk among others.

The capacity of a specific country, at a particular point in time, needs to be taken into account when choosing to go to split purchasing functions from the providing service delivery function. The purchasing agency needs to be able to take the best decisions to meet the needs of the population. They can be governed in a number of ways. Providers need to be able to respond to changing needs and shift resources accordingly. Countries like Rwanda had already gone that way, even utilizing multiple (competing) purchasers. This reflects the prevailing values or concerns over issues such as efficiency, equity, and choice within its health system.

In Kenya some counties significant investments in infrastructure, often without investments in other areas that were necessary to support the intended infrastructure improvements. For example, County *Zendi* purchased 20 ambulances but did not budget for the drivers or supplies needed for them to operate. Nor did they budget funding for capacity building.

Likewise, areas that appear neglected for other reason(s) might also fall into this working definition of resource-limited settings. Tertiary public hospitals in many developing countries are unlikely to be spared from this definition of being resource constrained settings either. For example, *Best Care Anywhere* might be a challenge where leaders fail to appreciate that every element of a larger system is a system itself.

A leader who is heading a particular service or department must see his or her role from the perspective of the whole system. The best way is to look at matters as if the section head was leading the whole system from the perspective of the particular service or department (Porter-O'Grady & Malloch, 2015). Unfortunately, this is not always the case for some Kenyan hospitals. Many organizations had suffered from the narrow focus of leaders who concentrate on their area of responsibility to the detriment of other component systems or the whole. Some departments have even held hostage the whole organization with highly unilateral decision makers.

As could happen when every nurse manager looks out for the interests of his/her department and staff, occasionally having to fight out with other departments to get what he wants for his own. In one such a hospital the overall leader was a paediatrics specialist and so he favoured the paediatric division in an obviously skewed manner. In other situations, the management focus on few program areas, with others ignored /missed altogether.

The Constitution of Kenya 2010 introduced a devolved system of government which would enhance access to services by all Kenyans, especially those in rural and hard to reach areas. The Kenya Health Policy framework 2012-2030 Section 5.2.1(viii) describes such marginalized populations to include those in hard to reach areas of the country, those in informal settlements and most at risk populations. This hopefully will address cases of political sponsorship with some areas desperately underserved while others had enough or more than.

Consider this data mapping the number of dispensaries in Kenya's counties per 10,000 people: Baringo County in the Rift Valley had 3.2 dispensaries/10,000 people, (the highest concentration countywide), while counties in North-Eastern had 0.0 to 1.0 /10,000 people. (A6_CountiesPopDisp.zip A6_CountiesPopDisp.shp).

The human resource equation is also considered in terms of resource-constrained settings; the patient workload that a staff - member can take care of safely. However, health professionals would need to weigh their duty to provide holistic care with obligations to their own health and that of their families in the event of extreme conditions, this was a concern raised by the American Nurses Association and said as much in a statement (ANA, 2010).

Health care workers could be said to be providing medical care in resource-constrained settings as a 'neglected group' in a system where medical staff frequently practices with inadequate access to colleagues who possess specialized training or resources. In these locales, a single clinician may act as the obstetrician, paediatrician, and surgeon *cum* anaesthetist and frequently did so with insufficient information/resources to effectively address the broad range of health issues affecting patient care or the guidance needed from specialist colleagues (Basow, 2013). Sometimes it won't matter that one was barely past intern.

Unfortunately, the Kenya government did not seem to actively regulate the number, type, manner, or geographic distribution of its health workforce, deferring to market forces instead. For example, of the 160 anaethesiologists in the country by mid-2017, 77 per cent of them worked in Nairobi. Some areas of this country for various reasons (not the least of which is insecurity) fail to attract health professionals of all kinds, creating true primary care deserts, but what is that best care they can give even in those circumstances? That is what matters and is the concern of this framework. But more important is how we can improve for the better.

Resource constrained might also mean staffs were less available at the workplace and working as was observed in the *Hivos study 2013* (a bit of it was covered in Chapter 2 in this book). The study agreed with several other studies before that showed absenteeism, and even when present some providers spent less than half of their time in patient care. Increasing the productivity of existing workers was almost always more cost-effective than hiring more workers, and in many resources constrained settings, hiring more providers may be impossible.

A hole in a Day's work: *A veteran nurse recollected with nostalgia how some her colleagues could spend most of their time while on duty promoting their personal businesses some sold snacks, books etc. Another one recalled that to some certain cadre or disciplines of medical staff barely, hardly had much in their hands day in day out and had all the time…a good number upgraded from diploma to completing PhDs while on duty. You wonder why they needed to post one or even several of them and their interns in each unit.* All these while others sweat. Quite frankly sometimes all one needed was an extra pair of hands to ease the pain on thehighly tasked cadres. But then they said ...it was you who chose nursing....blah blah

Best Care Anywhere is concerned that in some settings safety is not usually a *First* consideration due to several competing issues or utter sloppiness. The Kenya Patient Safety Survey 2014[52] published by the Ministry of Health in February 2015 was conducted in partnership with World Bank, World Health Organisation and the Danish *SafeCare-PharmAccess*. The report stated that "overall safety compliance was relatively poor, with less than one percent of public facilities and only about two percent of private facilities achieving a score greater than one in all five areas of risks assessed."

The facilities were graded on an ascending score of 0-3, reports. Only 13 of the medical facilities gained a score of more than one of the scale. 11 out of those 13 that scored above a one are private facilities. Less than six per cent of public hospitals achieved a score greater than one in having a competent and capable workforce. The report cast doubts onto the quality of medical care in hospitals Kenya as it showed that a patient's safety may not be guaranteed within some medical facilities and hospitals. The most problematic of the evidence came from only 13 out of 493 private and public hospitals gaining a passable score.

The report on safety at hospitals emerged on the backdrop of the Ministry of Health's admission that human error was responsible for the paralyzing of the 28 children in Busia County who fell sick after an injection(s) gone awry (see **Akichelesit dispensary** in Chapter 1). This raised a

[52] *www.health.go.ke/.../**Kenya**%20**Patient**%20**Safety**%20**Survey**%20Report.*

public outcry when the news came out around July 2015. These were among the numerous cases of medical negligence.

Several theories were postulated including injection neuritis with foot-drop, the possibility of contaminated drugs, injecting *Quinine* into the wrong site. Even polio had to be ruled out. Whichever might have been the case, concerning the culpable health care provider. The 28 were airlifted to The Nairobi Hospital for specialized treatment. The 28 children were later discharged from the hospital walking and in good general condition one month later. By July 2018 the compensation for the children was yet to be settled. Best Care Anywhere philosophy admits that *nothing could be worse than being honestly and sincerely wrong*. Or *to know the wrong thing too well*.

Best Care Any*where* should discourage what has come to be referred at the operational level as 'clearing and forwarding' practices (as happens in some clinical area settings). Usually, this involves doing work to finish the shift with little concern for detail or quality. This is something even KAIZEN 5S 1K (*sort, set, standardize, shine, sustain, keep it up)* program of total quality management has tried now and again to address, some gains have been realised in some centres but for a good number of them a Kiswahili word for this environment would be *'shagalabagala'* for: chaotic, messy, disorganized, anyhow. Otherwise, how does one explain a setting whereby less than adequate decontamination and sterilization practices still exist despite written protocols, mechanisms and supplies to facilitate them being widely available?

A student's feedback about rurals:

> *This being a rural setting, most personnel working in the health facilities reported to work a little later than expected of any health care provider. At times the facility would be opened very early for cleaning but the first clinician reported at 9 or 10 o'clock only to find long queues of patients who have been waiting.*

The concern of Best Care Anywhere is that with some of these malpractices it seems there are those that barely try. I would be accused of being unrealistic as if these supplies were widely available when they were not. This could be true, but things are never that easy anywhere, even where they work or seem work, even in the best of centres. Having worked in diverse settings from the very best to the not so good in Kenya, with a stint in the US health system as part of my Masters in Nursing Leadership and Health System Administration program undertakings, this author could confidently say much of it was a matter of deliberate and consistent effort.

We might also consider the following even if they may not always be resource-constrained. From time to time some health centres in big towns and cities became no more than consulting rooms with nothing else to offer. As happened at different points in the past, one or two facilities in urban settings apparently recorded maternal - neonatal mortality rates and surgical site infections, and several unbecoming incidents which were higher than any of the rural or traditionally disadvantaged facilities.

'Unattended delivery is unattended delivery whether it's happening in hospital or out of it… (if mothers are so many and you are so few or alone) in case of a complication which mother do you attend to?', these were the words of Dr. Nelly Bosire an official of Kenya Medical Practitioners & Dentist Union (KMPDU) Nairobi branch during a panellist discussion *Checkpoint* in one of Kenya's television. The interview focused on Pumwani Maternity Hospital where the ratio was 1

nurse to 10 mothers in labour ward which had 9 cubicles and 2 infant resuscitaires (WHO recommends 1:1).[53]

It was noted that with the introduction of free maternal health in June 2013 the number of women seeking health care at Pumwani Maternity Hospital had increased by 60%, (80 to 100 normal deliveries and 20-24 caesarean sections a day) while the staffing levels remained the same.

Again how does one explain a situation whereby a contraption in the name of an ambulance with a critically ill patient on referral will set out on a trip with the crew knowing too well that it lacks in any form of emergency or resuscitation equipment and supplies. Nor does it have a torch, neither a jack nor a spare wheel? In one such scenario several years ago this was what was covertly shared by one of those who witnessed it (see **The ill-fated escort** in Chapter 1 and **Shot and left for dead** in Chapter 2).

Best Care Anywhere was very much concerned with what happens en route, during transitions etc. It is concerned with those circumstances: the hands off, the gaps - a referral escort without a qualified staff; en-route transfer medication, resuscitation & stabilization of the patient; the longer than expected hours of delay; the deteriorating patient's condition; at whose expense do less than qualified personnel offering referral services; what about the sickly ambulances? More than enough *God forbid* examples are all over en route our health facilities. Thanks to the county governments, the ambulance(s) status remarkably changed in less than three years of devolution. We could then agree with a slogan Governors liked to use, 'the Only Devolution Can Do This!'

Having said this, the first county governments being pioneers, faced formidable challenges along the way as is always the case with forerunners everywhere. Some aspects of health care under devolution (notably human capital issues) took longer than expected to realize results, but the achievements were laudable. These lessons were important and necessary.

Resource constrained setting could also mean constrained space to work in. Many county hospitals had failed to expand in terms of space. There is a greater need for public land with many competing powers including private developers. Today we have a higher demand for women seeking to deliver in hospitals under the care of a trained health care provider but there has not always been corresponding effort to expand the maternity units and especially labour ward.

According to Porter-O'Grady & Malloch (2015) not adequately accessing additional resources or adjusting the focus of existing resources in a timely fashion creates a double demand on staff, further burdens them with additional work, increases their levels of emotional stress, decreases their ability to focus and respond to immediate issues of concern. The staff's inability to respond and the narrowly allocated resources with no financial flexibility created a serious constraint on the organization's ability to respond to crisis.

Should the emphasis by the government, employers, insurance providers and individuals be improved health rather than provision of additional medical services, which will lead to new

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53 KTN *Checkpoint* 2100Hrs. 7th June 2015; Available http://www.standardmedia.co.ke/ktn/?videoID=2000093919&video_title=women-at-risk-over-pathetic-state-of-pumwani-maternity-hospital

approaches to improve health (Feldstein, 2011 p37)? Imagine of a pyramid which is the Kenya health system, the size of our economy and the trajectory of where we are putting our money.

Rather than focusing on population-based services such as health education, immunizations, etc., which were at the bottom of the pyramid (the largest section that should in theory make-up the most of health care services), we were focusing more on treatment (and we want to go for the invasive treatment or the more-so tertiary) which is at the top of the pyramid (the smallest section that in theory, we should devote the least time and resources to in health care).

I say in theory because that is what it is – a theoretical, in practice we seem to prioritize more resources for the benefit of fewer people in the shiny projects. We seem to no longer desire to invest in health rather than invest in 'patching people up' (in critical care, renal replacement therapy, cardiac catheterization labs etc.). Were some of these projects priorities only to the extent that they are fulfilling political manifestos? Where is the trade-off for an economy like ours? (See

The concept of quality: Quality and safety are inextricably linked. *Quality* in health care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety (The Joint Commission on Accreditation, 2015). Patient safety emerges as a central aim of quality. *Patient safety*, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. Safety is what patients, families, staff and the public expect from health care organizations. As nurses advance in the art and science of nursing in a patient-centered healing environment through our professional practice and leadership that emphasize - *Extraordinary Nursing Care, Every Patient, Every Time.* This was the vision for nursing that stood at the center for the provision of high quality healthcare (Winter, 2015). It would be a journey if it is to be realized.

According to a report by Paige Minemyer on March 15, 2017 appeared in *Fierceheath*, hospital leaders and clinicians who own up to mistakes and work with patients after medical errors occur may actually avoid lawsuits. According to Richard Boothman, the executive director of clinical safety and chief risk officer who launched University of Michigan's reporting program, hospitals must "normalize honesty" to reduce errors and improve the response when one does occur. Proponents of the programs also worry that hospitals may use disclosure as a means to avoid Unwinnable or small malpractice suits. Available:http://www.fiercehealthcare.com/healthcare/apologizing-for-medical-errors-may-make-patients-less-likely-to-sue.

The concept of quality and the benefits that would be conferred to the health providers' work and the outcomes for their patients had not been completely understood by health managers and providers in Kenya (KQMH, 2011), yet patients are becoming increasingly aware of inadequacies regarding quality within the health care system. In a personal communication to this author, Annette Eichhorn-Wiegand, a Quality Health Management Systems Advisor with Christian Health Association of Kenya (CHAK) observed that:

> *The confusion in Kenya is far too large as every donor brings in its own quality system and as people have very little background of quality management and how the different models and systems are linked and married, it is often difficult for them and confusing.* It became necessary that as leaders in health systems in this country, it was our responsibility to shape things, define what was important to us, define the parameters, define the terms etc.

Aaron Donabedian, one of the most widely recognized expert on quality health care research defined quality care as "that kind of care which is expected to maximize an inclusive measure of

patient welfare, after one had taken account of the balance of expected gains and losses that attend to the process of care in all its parts" (Donabedian, 1990).

According to the Constitution of Kenya, Quality health care is a human right for all and also according to The American Nurses Association (ANA, 2010). ANA asserted that to improve the quality of care, healthcare professionals must address the following complex issues: increasing costs of care; health disparities; the lack of safe, accessible and available healthcare services and resources.

According to Porter-O'Grady & Malloch (2015), there was a general belief among members of the American public that health care was expensive, not safe and that the quality outcomes were less than desirable. If that comment could come from the US, where does that leave those in Kenya and the other developing countries?

Peter Senge (1999) on the other hand defined quality;

> *... A transformation in the way we think and work together, in what we value and reward, and in the way we measure success. All of us collaborate to design and operate a seamless value- adding system that incorporates quality control, customer service, process improvement, supplier relationships, and good relations with the communities we serve and in which we operate - all optimizing for a common purpose* (Web2. Concordia).

Definition of quality generally could be:

- Conformance to specifications measures how well the product or service meets the targets and tolerances determined by its designers
- Fitness for use focuses on how well the product performs its intended function or use.
- Value for price paid is a definition of quality that consumers often use for product or service usefulness.
- Support services provided are often how the quality of a product or service is judged. Quality does not apply only to the product or service itself; it also applies to the people, processes, and organizational environment associated with it.
- Psychological criteria are a subjective definition that focuses on the judgmental evaluation of what constitutes product or service quality.

The quality of health services: Definitions of the quality of health services according to community perceptions were reported in a study carried out in rural Uganda by Kiguli *et al.,* (2009). From this study, the community perceived that quality depended on a number of variables related to technical competence, accessibility to services, interpersonal relations and presence of adequate drugs, supplies, staff, and facility amenities. A summary is provided of the outcomes from the study (Please see Appendix 1).

From a more local angle, 'in Maua Methodist Hospital we define quality care or services as "doing the right thing, in the right way, at the right time, to the right person, using the resources available,"' as shared by Muriuki & Gitari (CHAK, 2013). Indeed this definition played quite well into the context of the proposed Best Care Anywhere Organizing Framework for Resource- Constrained Settings (BCAOFR-CS) as it underscored the vital role of what would be available in terms of resources. Enough cannot be said on the importance the right person, the technical 'know how' as opposed to 'know who' as witnessed in some biased appointments and placements that did not always look into merit.

Most quality measures had been designed to measure evidence-based care which rarely is the case in most resource-constrained settings of Kenya. Even in developed countries like the US, Agency for Healthcare Research and Quality (AHRQ) report admitted that quality health care varied depending on where one lived (AHRQ, 2005) and could not to be measured the same way.

Access to quality health care: The concept of access to health care described in relation to Best Care Anywhere has two or so major components: ability and availability. The first is ability to pay but availability is equally important. It is a decision that can revolve around a pool of factors depending on the individual. But generally of priority being health status, attitudes/perceptions, ability to pay, transportation, etc. usually in that order. Most importantly, the price of a service! The decision to seek a medical service, in a nutshell, will depend on the value placed on that service by the consumer (patient) in relation to the cost of that service.

According to Bodenheimer & Grumbach (2012): Accessible health care means availability of health care personnel and facilities that are close to where people live; accessible by transportation; culturally acceptable and capable of providing appropriate care in a timely manner and in a language spoken by those who need assistance. Therefore, access to health care would be simply measured by the number of times a person uses health care services. Access can also be quantified by surveys in which respondents report whether or not they failed to seek care or delayed care when they felt they needed it. The decision for seeking reasons or not seeking health care could be: -

***Ability to pay*:** If one can afford a service, they can most certainly obtain it! As people become wealthier, the theory was that they tended to spend more on quality medical services, they often saw specialists more, *paid more to wait for less or see a provider sooner*, etc. (Fielstein, 2011; p 49) "Having insurance changes a person's behavior" If someone has insurance medical cover, they are likely to utilize more services just because they have that insurance (Fieldstein 2011; p.55).

In the context of ability to pay, *Best Care Anywhere Framework* is also concerned with the decision to seek care. Not much data was available about Kenya but some data was gleaned from among others *The Commonwealth Fund 2011 International Health Policy Survey of Sicker Adults*. "Sicker adults," were defined as those who rated their health status as fair or poor, received medical care for a serious chronic illness, serious injury, or disability in the past year, or were hospitalized or underwent surgery in the previous two years.

This survey reported that about four out of ten adults with below-average incomes in the US reported they had a medical problem but did not visit a doctor in the past year because of costs. More than one-third (37%) of the U.S. adults surveyed reported forgoing a recommended test, treatment, or follow-up care because of cost. This is not just a matter of access but also of equity and affordability. If that could happen in the US then it's not hard to imagine worse situations in resource-limited settings of sub-Saharan Africa.[54]

Some of the population we serve receive too little care because they are uninsured, inadequately insured, premiums deducted by employer may not remit or what some call ''bare bones insurance card' for its characteristic *low cost and scanty benefit package* not accepted in some

[54] The Commonwealth Fund. New York, NY, June 16, 2014 http://www.commonwealthfund.org/publications/press-releases/2014/j...

practitioners/institutions. Subsidies, as it were, may not always offer adequate options or deliver good quality services.

Medical insurance sought of masks the "true cost" of health care. It has an invaluable contribution to quality healthcare thus has been alluded to severally in this book. Examples of such desperate situations have been highlighted severally in the media especially of plantation workers e.g. *Majani Mingi a* part of Lomolo, Katani, Mogotio and Banita, Solai in Nakuru County. This is a community based around the sisal industry. A good number of them were internally displaced due to post-election violence of 2007. For places that were hardly 50km away from Nakuru town, the abject poverty and incongruent health care situation was puzzling.

The presence of a functioning, responsive public health systems was key in turning around the health status of residents in many such locations. This resonated with some stanzas from a poem *Serikali Saidia* [paraphrased from Kiswahili - asking for help from the government] by Kenya's Poet *Tear drops* who goes on the same name on social media:

... serikali over here
serikali over there
serikali everywhere
serikali saidia
kilio ni kilekile...

[Paraphrased*: If the government was everywhere, why were residents perpetually begging it to come to their aid?*].

According to Gulliford and Morgan (2003), access was concerned with whether those who need care could gain entry into health care system. They observed that those with the greatest health needs experienced less access to preventive services, primary care, and secondary care.

Components of quality health care as identified in a WHO (Roemer, 1988) on Primary Health Care were a combination of *access* (whether individual could access health structures and processes of care that they need when they need it) and *effectiveness* (the extent to which care delivers its intended outcome and results). When consumers had concerns regarding quality, they may question equity of service, quality, standards, distribution, allocation and consistency of the quality of service.

Equitable access does not necessarily mean equal travel times for all services or that all services are available locally (Berwick, 2012). According to Berwick, the principle expectations of quality of care in rural (as well as urban) areas ought to be equal for non- emergency services providers choose to deliver. Residents of small rural communities often have to travel further to see specialists because (take or leave it) there too few residents to support some specialties.

The relevant benchmark for emergency services for a rural hospital would be if the rural hospital no longer offered emergency services and patients must travel farther for emergency services (Berwick, 2012), and that is where Best Care Anywhere common sense come in. '*A hospital that is really a hospital and not one by name should have the ability to offer emergency obstetric care*

including post abortal care', remarked Prof Karanja, Obstetric/Gynaecologist in an interview in one of Kenya's leading TV station in a program *Family matters*[55].

While these were findings may be true for the US where this report emanated, it might not be so for our case since it would appear unfair to determine access by accounting for levels of staff, patient volume, and technology etc. For example, how many urologists or oncologists for that matter can rural (as well as urban) residents in Kenya can access in a given radius? For many counties in Kenya, to even have one of them practicing there would be a great privilege. It was said that there were only 20 oncologists in Kenya by early 2016.

Increasing client(s)' access to Best Care Anywhere care: *'...means reducing or eliminating the possibility that an individual will be unable to pay for such care, or will be impoverished as a result of trying to do so'* (WHO, 2000).

Kenyans worked hard (many struggled to make ends meet) but does it guarantee them a future in case of a medical emergency? When a health problem cripples one's life? For a good number, financial costs of living with a chronic condition had mainly been dependent on the mercy of family, friends, and well-wishers if life had to go on. Sort of *living on borrowed time*. Conservative figures in 2017 indicated that a kidney dialysis, for example, cost Kshs 4500 in a public facility to Ksh15000 weekly in a high-end private facility. The kidney transplant was estimated at Kshs 500,000 in public to 1 to 2 million in private facility. This did not include hidden costs of medication and access among other prohibiting expenses.

Financial protection is commonly measured in terms of "catastrophic" and "impoverishing" payments resulting from out-of-pocket (OOPs). Catastrophic payments tell us that a household's OOPs are so high compared with what it can afford, that they may forego other essential goods and services. Or rather catastrophic payments are greater than a given proportion of total household expenditure (or income); impoverishing payments are when a household is pushed below, or further below, the poverty line i.e. change in household living standard after service use.

We can measure the economic impact of OOPS in terms of the extent to which people have to sell assets such as livestock, or pull children out of school, in order to find the money to pay for health services. There are often large in-country differences in access to health care, for example between rural and urban areas, a household's capacity to pay, and many other factors. Measurement, therefore, needs to focus on the individual actually using health services and how they are affected.

The percent of population covered by an insurance scheme, doesn't capture the actual effect on the individual or household concerned - indeed in some cases, being insured in some cases had led to higher OOPS for individuals, where they end up having to make large co-payments, or pay for services such as diagnostics and outpatient medicines not covered in the benefit package.

Other specifics arrangements of an insurance scheme, for example, how they pay providers, can also have a huge impact on how well the insured person is actually protected financially. Other indirect costs since social protection schemes did not cover related costs such as the purchase of medicines, the need to pay for transport to a health facility, need to have someone 'stay with'

55KBC Channel 1 TV *Family matters*, 5th June, 2016 22Hrs

with the admitted patient as well as waiting time. Since these do affect financial protection, they should also be considered though they were rarely measured systematically.

Providing financial protection from exorbitant out-of-pocket expenses is an important tool for a country's health system to ensure equitable access to care and ensure families are not unnecessarily faced with financial catastrophe and impoverishment. This is often difficult in Kenya since out of pocket expenditures remained the largest contributors of health funds, the expenditure came to almost 67% of personal expenses. The government is tasked under The Health Act, 2017 Part *X* **Health financing** Section 54,

(1) The Ministry of health shall ensure progressive financial access to universal health coverage by taking measures that include: (a) to develop mechanisms for financial and risk pooling to progressively reduce the out of pocket expenditure; (d) to develop policies and strategies that ensure realization of universal health coverage.

Catastrophic Health Expenditures and Impoverishment in Kenya (2003-2007) analysis revealed that in 2007 an estimated 2.5 million people were pushed below the national poverty threshold as a result of paying for healthcare. Typically these kinds of studies generally did not consider the source of the funding for the families. They usually omit indirect health care costs (for example, transportation, loss of work), which can be a substantial proportion of health spending.

Results from this analysis provided strong evidence for the need to implement policies that offered more financial protection to the poor and vulnerable in order to achieve the country's overall goal of universal health coverage. *Catastrophic Health Expenditures and Impoverishment in Kenya* is available from http://www.healthpolicyproject.com.

One report defined geographical access as up to one-hour walking distance, indicating that 50 percent of the population has access to public health facilities, 70 percent of private health facilities, and 80 percent of retail outlets (HERA, 2005). Even though this report failed to indicate the significant disparities that existed between urban and rural settings and between various regions of the country.

Access to health care does not guarantee good health because there are other factors such as social-economic status, genetic etc. but without such access health is certain to suffer. Even with access each attempt to solve a problem like e.g. insurance, in turn, creates a new problem by stimulating a rapid rise in health care costs.

Service delivery: Even when it looks like Best Care Anywhere is a tall order we must endeavour to deliver a service that is effective, safe, quality personal and non-personal health interventions to those that need them, *when and where needed*, with minimum waste of resources. It can also mean demand for care, service delivery models and integrated packages; leadership and management; infrastructure and logistics.

The Institute of Medicine (IOM) report summarized ten rules for the delivery of care that were essential for a redesigned system (ACMHA, 2008), the kind envisioned by Best Care Anywhere framework.

These includes: Care is based on continuous healing relationships; Care is customized to patient needs and values; the patient is the source of control; Knowledge is shared and information flows freely; Decision making is evidence-based; Safety is a system responsibility. The fair and just *safety culture* of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behaviour that determine the

organization's commitment to quality and patient safety (The Joint Accreditation Commission, 2015); Transparency is necessary; Needs are anticipated; Waste is continuously decreased; Cooperation among clinicians is a priority.

Best Care Anywhere adds an 11th one - on reduction of abuse ('in all its form'…) as case sensitive for the Kenyan situation because patients who believe the provider is one who has their interests at heart, show greater satisfaction with the care received and are more likely to comply with treatment regimes. Some health care workers have exploited this goodwill and taken advantage of patients (See Construct number 2 above).

The publishing of a report entitled *Crossing the Quality Chasm*; a New Health System for the 21st Century by the Institute of Medicine (IOM) was a big step towards describing access to quality care (IOM, 2001). In this report, the term "health care system" refers to the organization, financing, payment, and delivery of health care as described in greater detail in the IOM report. The report defined a framework for the quality of a health care system, laid out six "STEEEP aims for improvement" (as outlined below) as a useful blueprint that could help guide decisions about what aspects of could be measured:-

Safe (S): The system should be safe (i.e., free from accidental injury) for all patients, in all processes, all the time. For example, there should not be lower standards of safety on public holidays, weekends or nights. Patients should only need to tell their health care providers information once, and health information should not be misplaced, lost or overlooked.

Timely (T): The system should deliver care in a timely manner (i.e. without having to wait on long queues that were wasteful and often anxiety-provoking). This domain addressed access issues.

Effective (E): The system should provide care that was effective, based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcomes. This domain concentrated on the appropriateness of care (i.e., care that was indicated, was as prescribed by protocols or was it given as per the clinical condition of the patient?) and addressed the problems of overuse and underutilization of health care services.

Efficient (E): The system should be efficient (i.e., use resources to obtain the best value for the money spent). This IOM domain addresses the underlying variation in resource utilization in the health care system and the associated costs.

Equitable (E): The system should be equitable, meaning that care should be based on an individual client's needs, not on personal characteristics (such as gender, race, or insurance status) that are unrelated to the patient's condition or to the reason for seeking care. Health disparities are defined as differences in treatment provided to members of different racial or ethnic groups that are not justified by the underlying health conditions or treatment preferences of patients.

Patient-Centered (P): The system should be patient-centered. This concept encompasses the following: respect for patients' cultural values, preferences, and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support (i.e., relieving fear and anxiety); and involvement of family, significant others, and friends.

A Best Care Anywhere environment ought to be able to measure all the six "STEEEP aims for improvement" domains. Even if this were not the exact case for resource-constrained settings we might be able to measure a number of them using Kenya Quality Health Model (KQMH) by adapting some tools for doing so. Even patient safety may be at its infancy in Kenya there are now concerted efforts embracing quality management systems (ISO 9001:2008 etc.) certification by many health care institutions in the country.

A seminar on stakeholders on quality health care from Kenya and beyond in June 2013 recommended that KQMH could be used as an accreditation standard for health care institutions in Kenya (Technical Report, 2013). At least it's home grown and has lots of input that take care of our unique circumstances.

The Kenya Essential Package for Health (KEPH) outlined provision of comprehensive, integrated curative and preventive health services, available at the first point of contact, accessible to all (MOH, 2006). Towards this end, some attempts have been made by the Ministry of Health (MOH) to improve the quality of health care services. These include, among others: building more health facilities, providing more medications, recruiting more health workers and training health workers through education.

In their paper entitled '*Fundamentally updating fundamentals*,' two renowned nurse educationists Armstrong & Barton (2013) argued that quality (and patient safety for that matter) is no longer an elective content area in nurse education basic training. However, many curricula in Kenya were yet to include this concept.

Health Outcomes: Just as quality is equal to health outcomes (Porter, 2012, Porter-O'Grady & Malloch, 2015) so is Best Care Anywhere which shows some explicit health outcomes below:

It matters a lot that our provider sensitive quality indicators meet and exceed our targeted goals, but it is also critical that we address issues (see table above) that our clients perceive as quality indicators by our clients. That is even if there were no other scientific ways to measure Best Care Anywhere.

Health care providers deal with human beings at their most vulnerable moment which requires the providers a high level of personal involvement. If the aspirations of Kenyans concerning health are to be realized, healthcare providers and health care organizations need to work to ensure that the patients:

Experience an improvement in their clinical condition, possibly including increased physical functioning, greater tolerance of activity, improved ambulation, and/or reduction of pain.

Improve their ability for self-care, including performing wound care, taking medications on schedule, maintaining a nutritious diet, eliminating properly.

Learn more about their condition and its treatment, including their own treatment regime, appropriate procedures, potential complications, what to do in emergency situations.

Are aware of the elements of healthy lifestyle, including proper nutrition, weight management, activity, stress management, sleep, safety, infection prevention and control practices, disease screening. Acronym: Early Periodic Screening, Diagnosis, and Treatment programs (EPSDT). According to AMREF (2012), one approach to effective service delivery is by creating demand

through: knowing about health needs, increasing quality of care, improving health literacy, increased medical insurance cover, and good behaviour and attitudes of health care workers.

A clean environment, meals delivered on time at the right temperature and pleasant to eat, medication is given when due (or when requested), comfortable space for the significant other where indicated- a calm healing environment for patients and their families.



Table: Quality is equal to health outcomes

(Used courtesy of the clip developer)

According to Porter-O'Grady & Malloch (2015), the future of health care will depend on the ability of the clinical systems to interface well and work together across disciplines and the organization, to adjust to increasingly complex technology applications, to operate in a high–mobility accountable arena, ensure that the health needs of individuals are met and the health of our communities is advanced.

Patients face significant burdens every day when trying to navigate the health care system, including choosing a provider, trying to find affordable care, and determining what treatment will be best for them, not to mention literally the time wasted *getting lost,* not knowing where what is, missing directions while within the health facilities. We cannot even begin to talk about waiting time here; it's a whole topic for another book.

In resource-limited health care settings, there was need for policies to direct and evaluate access to quality health care and guide the organization's operations at different levels to see how they can be brought to par on a basic minimum. This is a tall order that calls for change in attitude, priorities and having the interests of the patients at heart at all times by all concerned. Sound policies based on a solid base of data and evidence is the cornerstone of every country's health systems.

The Health Policy Project (HPP) works with partners in Kenya to strengthen the country's health systems during the transition to a devolved system of government and a decentralized health infrastructure. The programs provide technical assistance to strengthen the use of data and evidence in formulating effective new health policies and laws. They also work with government and health institutions to develop effective and efficient financing mechanisms that maximize the country's funding resources to deliver high-quality, equitable, and affordable healthcare services to all Kenyans. Available: http://www.healthpolicyproject.com/index.cfm?id=country-kenya



(Image Courtesy of Ballocartoons)

Care about that life because that life could easily be anyone. Circumstances may not always favour the care providers no matter what part of the divide they are in: It is not too hard to imagine a scaring moment like where one might land as an 'unknown African male adult' (UAMA in medical acronym) who was involved in a road traffic accident last night. Be it as providers or recipients or even the diverse socioeconomic status one might land anywhere at some ungodly hour on a fateful day as seen in the following example shared covertly (see **Unknown Male African Adult** and **Zusha** below).

Unknown Male African Adult

Every day an emergency occurs. It could be someone you know, it could be you. Let us learn from the following incident:

A grizzly happening was shared to me on how two decades or so back, anaesthesiologists from all over East Africa held a conference in Uganda. On their way back some of them were involved in a road traffic accident somewhere along Nairobi-Eldoret highway. Good-Samaritans took them to one the resource-poor hospitals at the time: it was not possible to get two working stretchers or resuscitation (including intubation) equipment in the emergency department. Some of the casualties were still conscious and tried to introduce themselves - that they were doctors, but apparently, this did not help much. It was said that one of them who had sustained a possible cervical spine fracture could still talk and requested to be intubated, unfortunately, it could not be done … helpless … a cervical collar was news to the staff then … Certainly the outcome was bad (a source close to an eye witness). Remember that with trauma time is of essence. [It was not unusual to come across an Emergency Departments or ward with trolleys with castor wheels that did not rotate, or one of the four wheels missing or there were no stretchers all together].

Post script

Establishment of trauma centres along the black spots have remained part of strategic plans forars. Funding was always a step away. It had not been possible either to sustain the emergency rescue centres to offer a reliable rapid response team. Rescue centres often times were launched with pomp and peagentry after sirens and fire engines in the aftermath of serious road traffic accidents with reassurances such as 'You see from now on…blah… blah….' One such a site houses a mausoleum mass grave of tens of *'Sachagwa oil tanker fire victims'* unidentified bodies in January 2009. It was unfortunate that this inferno killed more than 150 people, more being rescuers than the original casualties. Majority of Kenyans have moved on after these tragedies but the realities remain - it could happen again, to anyone.

St Johns Ambulance Emergency Rescue Centres were established along the Nairobi –Eldoret Highway, notably at Sachangwan, Limuru and Kinungi black spots among others. These had since been inoperational for some unexplained reasons. The stand-alone containers turned rescue centres were a ghostly site yet many road traffic accidents (RTA) casualties continued to be witnessed, some died while others suffered disabilities.

WHO (2013) report showed that there were no comprehensive emergency surveillance system and no specific contact numbers available for road accidents. Response was slow, uncoordinated and uncertain. PDF available: www.who.int/../factsheet_afro.pdf

Health care workers are human after all, illness knows no profession. In sickness we all just as vulnerable

– the words of Dr N. Bosire eulogising the late Dr AM who spent hours trapped at a ferry crossing from South Coast [See newspaper cutting below]. The ferry could not break its schedule to honour an ambulance flashing sirens. He needed blood transfusion urgently, since there was none, he bled to death. The death happening the day of th repeat presidential election 26th October 2017 and during the nurses' strike generated a lot of reactions on mainstream as well as social media. The author of this book and the deceased were students at Moi University at the same time.

Then there is what I would call an outsider looking in. I choose an an article 'Our hypocrisy is the real problem with our health care' by Tracy Liloe in *Africa Health Report* on Friday, August,2018. The story was around a young doctor who even after being attended to by very 'very many' doctors some as professional friends and obviously as her care providers had died least expectedly just hours after a caesarian delivery in a private hospital.

Most times the casualties may not complain or have the presence of mind to know what ought (not) to have happened. This will be the most likely assumption: Whatever happened was anunusual episode; So much for that; whatever happened; and wish it away...; until something else (bad or worse) happens again.

Public relations departments may often be put to task to do damage control in what had come to be referred to as crisis communication strategies. There has been more than enough window dressing but less of action, action, Action! We are yet to begin sustained solutions to many of the perennial well known societal ails. We need less of we shall do and more of we have done. To start with how is it that it has not been possible to deal with lawlessness on our roads? Have rapid response teams and trauma centres in all our hospitals and along major highways?



the broken system he tried to fix

BY DR NELLY BOSIRE

A WHOLE COUNTY HEALTH SYSTEM DID NOT HAVE A PINT OF BLOOD TO KEEP DR MAKOKHA FROM BLEEDING TO DEATH

Newspaper cutting (above) appeared in *Healthy Nation,* Daily Nation 31st Oct. 2017. Expose` by Dr N. Bosire, A tribute eulogising A.M., a medical doctor who died enroute on referral from South coast Kwale County. He needed Blood transfusion urgently but bled to death since there was not a pint of blood in the whole county. He ought to have been a beneficiary of emergency evacuation by air/land/sea since he was a senior medic at that who had served his county and country well. A befitting title: 'The irony of patient defender felled by the broken system he tried to fix'. The ambulance with flashing sirens had to wait at the ferry crossing for hours.

In June 2017, the NHIF entered into a partnership with Emergency Plus Medical Services (*E- Plus*) to roll out emergency road rescue and evacuation services. This is meant to benefit all NHIF members and their declared dependants. See **section 4.9.2** of this book on Universal Health Cover.

A motion was brought to the 12th parliament by Hon. Melly, M.P. The discussion on 29th November 2017 sought to design service lanes for emergency vehicles. It can only be hoped that in the spirit of the motion, there would be means of implementing the same at national as well as the counties' level.

KNH the tower of hope amidst challenges

Kenyatta National Hospital has been associated with milestones and ills in the same breath. Stories of medical firsts like the separation of conjoined twins are juxtaposed with allegations of negligence, insecurity, overcrowding, long treatment waiting lists and broken down equipment.

'There are inadequate public health facilities in Nairobi and its environs so we end up providing primary and secondary level of care instead of concentrating on our mandate of providing specialised healthcare on referral basis. The referral system is broken. Hospitals at lower levels should act as a filter, but they don't, so we end up treating patients who do not meet the referral criteria and who should otherwise have been treated at the lower levels. his overstretches us.

Patients in critical condition are also brought in without following protocol. The referring hospital is supposed to call to confirm whether the facilities needed for treatment of the referred patient are available. Sometimes that doesn't happen, putting KNH in a very precarious position' 'There has to be corresponding improvement in lower level health facilities so that they can take up their responsibilities and leave KNH to concentrate on specialised services'. Lily Koros CEO talking to Healthy Nation's Merab Elizabeth on 20th Feb 2018 KNH boss talks about the problems bedevilling the national referral hospital See also: https://www.nation.co.ke/news/KNH-nurses-blame-lack-of-tagging-for-surgery-mix-up/1056-4342244-gc4qmxz/index.html,

But then KNH itself needed to improve on its systems to avoid errors. Consider the following: "That night we had 61 patients against two nurses," MN not the real name added, responding to Parliamentary Committee on Health which was probing the brain surgery mix-up. The mistake was however not noticed even after the surgeons in the theatre called the ward twice upon realising that the patient on the table was not AN, but the nurses there confirmed the identity of the patient as being right. Based on a medical scale (Glasgow Coma Scale) used to measure coherence of patients, at the time of preparing the patient for surgery, he was not coherent, scored a 13 out of 15. It became apparent that KNH then did not have appropriate mechanisms for labelling patients. The two patients had since been discharged and were recuperating well.





Pic: Which way Kenya's public health system? (Courtesy of the clip developer)

Kenyatta National Hospital (KNH) one of the national two national referral hospitals in the country was the microcosm of the ailing public health system. Anyone remembers the callous #KNHrot ,#KNHsaga on Twitter in 2018? It touched mainly on patient safety (including allegations of rape of post natal mothers living in the mother's hostel who had to go every two hours to breast feed their neonates two floors down at the new born unit). Other issues that arose included a public perception of an insensitive hospital leadership among others. It was hard to know where truth lay in this saga, victims were unwilling to volunteer information, while social media was prosecuting the matter based on generalities and conjecture. However Investigations were ongoing by the time of publishing this manuscript.

One thing was for sure - the country's health system was at cross roads, sinking lower and lower in the period 2017-18. Which way Kenya's public health system? There were no ready answers, by gleaning the comments on mainstream media and social media perhaps one might come across some good suggestions. One O.C.O on Jan 18, 2018 tweeted on the trend #KNHrot '…we need to shock the system and retain Kenyans who will serve and policy leaders who will not steal'. A great pointer to the way forward though it fell short of showing how to do that. We must embrace International Patient Safety Goals (WHO).


Pic: Patient safety is paramount, was an important pointer to the quality of health care. (Courtesy of clip developer)

In the immediate period following the brain surgery patient's mix-up of early March 2018 due to possible mislabelling, many Kenyans felt something needed to be done to address the KNH crisis. It was felt that just like one media house posed the question: 'What is the worst that must happen to KNH before something drastic is done?'

-I*n this case two Unknown African Male Adults -(?may be had names with possibility of a 3rd one) all in coma following head injury. One of them was diagnosed with an intracerebral haematoma was due for surgery to evacuate the clot. It was only after like 4 hours of looking for the pathology, calling in 2nd 3rd aon call that it was concluded that this was the wrong patient on the table. So they reversed the pateint as we say theatre. Meanwhile the right patient's general condition was deteriorating and had to be taken to ICU. A third patient (perhaps a confounder) succumbed to head injury after missing the opportunity for surgery. The incident missed basic but vital procedures before and during the operation, which resulted in one of the worst cases of medical malpractice. This led to a cascade of events, a wake up call as will be seen here below.*

The situation was made worse when over 700 doctors (mainly registrars and interns) downed their tools in solidarity to their suspended colleague in the neurosurgery mix-up and the suspended KNH CEO. Specialist consultants numbering 300 threatened to join in adding their voice to working in an unsafe working environment. They cited the mix-up as a tip of the iceberg of the system failures that bedevilled the public health system especially KNH.

In a press conference with one of the media houses on 6th March, 2018 the specialist consultants alleged that KNH had only one working CT scan machine serving the over 2400 patients. The MRI had broken down for sometime and a good number of essential equipment was lacking. The question of patient identification they indicated was somthing that could be sorted out with barcoding as an add in to digitization of electronic health information, and it would cost perhaps Ksh 100m. Compared to Ksh34b (leasing) medical equipment program. They lamented that KNH had not benefitted from the medical equipment program which had targeted the county hospitals.

It was notable that this was also during a time that university lecturers servicing the medical schools had downed their tools due to a pending CBA, The university teaching staff had just began another strike (one in a series of industrial actions from the previous year 2017).

Other cadres of health workers at KNH had also threatened to follow suit. Nurses especially felt that they were being victimized for system failures. Come to think of it - how many near misses could likely have ended up like the mix-up above? A fail-safe system failure was evident even though doctors tried to absolve themeslves of any wrong doing and placed the whole blame on one ward nurse. Bridging these gaps is about assuring access to quality care 'Best Care Anywhere'. The government has since contracted an audit firm to look into the systematic quality assurance failures facing KNH.

The battle had just began. This book cannot fathom what was about to happen to Kenya's public health system. One thing was for sure- the stem will need a beat and a heart to survive this one. It was the prediction of this author that Kenya's oldest referral hospital would get a new lease of life but at an enormous cost in terms of patients' suffering.This is what many had been saying all along - upgrade the former 8 provincial hospitals to be equal in status to KNH or MTRH, this will in effect decongest the two. In March 2018, Nyali MP Mohammed Ali presented a bill in Parliament that sought to compel national government to establish referral hospitals across all the 47 conuties in the country.

The main concern for Kenyans ought to be - can the next door (proximity to the incident or accident) health facility diagnose and treat a health problem you might have? That is - irrespective of who the patient was.

6.5.1 Leadership with a conscience

'Leadership with a conscience' was a phrase that one of my teachers and mentor Prof. Kafu (then of Moi University then became Dean School of Education University of Eldoret of liked to use. These were values he passed on to this author.

Best Care Anywhere envisages leadership with a conscience. Such leadership and soul-searching may be more than will be needed to address inaction, disparities, and issues of integrity among other concerns. The summaries of group work in the leadership is collaboration, listening, asking, discussing. A leader with vision has a clear, vivid picture of where to go, as well as a firm grasp on what success looks like and how to achieve it. But it's not enough to have a vision; leaders must also share it and act upon it.

A leader must be able to communicate his or her vision in terms that cause followers to buy into it. He or she must communicate clearly and passionately, as passion is contagious. A good leader must have the discipline to work toward his or her vision single-mindedly, as well as to direct his or her actions and those of the team toward the goal. The action is the mark of a leader. A leader does not suffer "analysis paralysis" but is always doing something in pursuit of the vision, inspiring others to do the same.

A case study

This author mentions Dr. Wilberforce Otchilo because he believed he was a leader with a conscience (one of the few if not many Kenya had), case study that needed follow up.

In an interview with a national media station[56] (the outgoing MP Emuhaya then vying for gubernatorial Vihiga County) emphasized the following points: The operation of the governor was guided by the constitution and the law. The core of devolution was about public participation but there must be modalities of how this was to be done. His initial plan would be to have a team to collect from the grassroots then come up with a public participation policy.

He aimed to have a *Country Assembly Act* on public participation. If indeed it was the community that ought to set agendas for their leaders and not the other way round. Dr. Otchilo was one of top performers amongst all MPs in the 10th and 11th parliament. In his manifesto for the gubernatorial in 2017, he envisioned being a passionate leader who believed in service delivery, honesty and forthrightness to the extent that the electorate responded 'if you can do these we will be happy and we don't need handouts from you'. That he (Dr. Otchilo's) word was bankable, when he said what will be done, it would be done. A leader who was forthright just as he said and who understood the concept of service. Who would tell you what he believed in and what he did not, learnt what he had to live with. Whenever he worked, with different actors every time things seemed to flow. His stature and aura of being in charge spoke on belief in his staff and constituents because he knew what they wanted.

[56]KBC TV and Radio, Sauti ya mkenya. 8-9 pm 11th July, 2017. Program *Frontline*

From his impeccable public service record to being a United Nations employee he seemed to be one who learnt quickly, an active planner, a hands on person. He seemed to prepare well for succession dynamics as well as for the next assignment.(**Post script**: Dr Otchilo was to become the 2nd Governor of Vihiga County in August, 2017).

Furthermore, this *section on leadership with a conscience was modified from a presentation entitled* ***Participative Leadership*** *held at Kakamega, Kenya 2015 by Kaijaleena Serlo, Ph.D. of Oulu University of Applied Sciences – Finland.* With gratitude to members of the 8 groups that worked hard to come up with the suggestions listed below):

Integrity is the integration of outward actions and inner values. A person of integrity is the same on the outside and on the inside beyond reproach. Such an individual can be trusted because he or she never veers from inner values, even when it might be expeditious to do so. A public officer holds the office on public trust, so he/she by default exposes themselves to public scrutiny. Honest dealings, predictable reactions, well-controlled emotions, and an absence of tantrums and harsh outbursts were all signs of integrity. A leader who is centered in integrity will be more approachable by followers.

Dedication means spending whatever time or energy is necessary to accomplish the task at hand. A leader inspires dedication by example, doing whatever it takes to complete the next step toward the vision. By setting an excellent example, leaders can show followers that there are no nine-to-five jobs on the team, only opportunities to achieve something great.

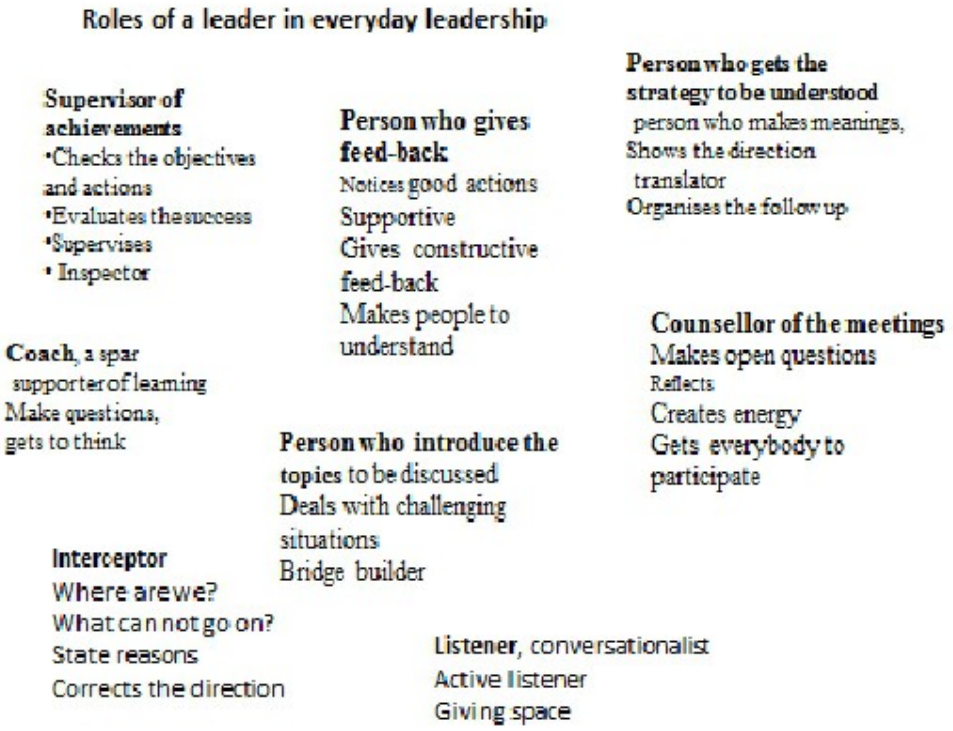
Magnanimity means giving credit where it is due. A magnanimous leader ensures that credit for successes is spread as widely as possible throughout the company. A good leader takes personal responsibility for failures. This sort of reverse magnanimity helps other people feel good about themselves and draws the team closer together. To spread the fame and take the blame is a hallmark of effective leadership. The buck stops somewhere as has been often said and, moreover 'bottlenecks are at the top of the bottle'.

Leaders with **humility** recognize that they are no better or worse than other members of the team. A humble leader tries to elevate everyone. Leaders with humility also understand that their status does not make them a god. Mahatma Gandhi is a role model for Indian leaders, and he pursued a "follower-centric" leadership role.

Openness means being able to listen to new ideas, even if they do not conform to the usual way of thinking. Good leaders are able to suspend judgment while listening to others' ideas, as well as accept new ways of doing things that someone else thought of. Openness builds mutual respect and trust between leaders and followers, and it also keeps the team well supplied with new ideas that can further its vision.

Creativity is the ability to think differently, to get outside of the box that constrains solutions. Creativity gives leaders the ability to see things that others have not seen and thus lead followers in new directions. The most important question that a leader can ask is, "What if …?" Possibly the worst thing a leader can say is, "I know this is a dumb question ..."

The leader is in the centre of six things: Be open to new ideas; Appreciate top know-how; Make sure that the workers know an essential information; Measure your time like it was of gold; Provide meaningful feed-back regularly and real time; Take "the conflict ox" from the horns.



(Used courtesy of the clip developer)

Some research showed that nurses perceived as excellent leaders were risk takers, were guided by fundamental philosophies, were strong advocates for nursing, and were supportive of their staff members. Research had also shown that participative managers who encouraged and valued feedback from all staff members were the most successful. Additionally, leaders who were visible, accessible, and had excellent communication skills had more success than leaders who didn't possess these qualities.

'If I ever found my way to a leadership position, I would begin by creating an environment that emphasized morale, honesty, integrity, and professionalism', Beck told *The Hospitalist.* If we desire and deserve quality service (healthcare included) then we must be ready not to put up with mediocrity or shoddiness and challenge what is not quality service. It may not always be possible to see it this way, but understanding contextual factors coupled with a conscious effort to rise above mediocrity may be what determines why in poor settings, some health facilities function unusually well (Rowe *et al.,* 2005).

It will be difficult to delight in any excellence unless we are persuaded that we either do possess or may possess it. Whatever we admire in terms of quality health care we can, in some measure, possess because it is a cherished wish. Doing nothing is not an option.
(See the poem **Zusha** by this author that appeared in *Human Touch Journal of Poetry, Prose and Visual Arts* Vol 9, 2016, 57 below).

Zusha

Zusha [Swahili word for protest, Speak up] campaign
makes a clarion call on Kenyans to: Speak up.
Tis´ an effort in the right direction–
Urges passengers to speak against reckless
driving on location.

It targets effecting behaviour change;
making safety a personal responsibility.
But then are they, not the same Kenyans who in some
parts of this country rebuke others who dare speak;
look you curiously for fidgeting for the safety belt? Or
'carefully observe' that the complaining passenger
-must be a new one to the route.

The average Kenyan passenger is a double standard -It depends
person. In some trips, he is heard to say–once the matatu
(a taxi van) is full (and by this, he means–one passenger per seat),
'let's go!'
In other circumstances, he is a passive one that will
ease up that same space so that many more can come in;
including helping create an illegal makeshift link 'sambaza-seats'
in all available aisle and leg spaces. The Koda (*ad-lib)*, 'starehe
ni kwa wheelchair'; You will sit all you want the day you get
confined to a wheelchair.

As together with his caged devotees,

the driver slows to a mean walk,

a traffic checkpoint, a tipping distance away.

To make an instalment, everyone smiles with that knowing look.

We are all Kenyans, all the time.

After all; We are in this together.

Time is of essence. So;

Toe-speed spurred was our chopper, I

clicked, someone did.



One day a desperate sojourner burst out reminding

fellow passengers; even as they overload, there

would be no gauze bandages or gloves in the hospital–

Should there be any injuries.

God forbid if;

The nurses might have made good their notice

and there would be no one to receive us,

lest one becomes like John Doe, the Unknown African Male adult. He who could not 'pay an arm and a leg'; for care in the private hospital.

From the confines, another passenger pronounced;

in no uncertain terms that–everyone involved would not be–

Be what!?

Be eligible to any insurance compensation should they get involved in

an accident.

They glared at the 12x3 inches Zusha stickers,

a few shook their heads. Someone muttered, 'sasa hii ni nini?'

Swahili for what's this now?). They seem everywhere.

How do they tolerate the stickers; these matatu people?

A sicker sticker portrayed a dead body on a

stretcher; another sticky one seemingly had resisted



attempts to scrape it, showed an incongruous

mangled wreck of a look-alike matatu. Same

Sacco– How comes?

No one could dare 'Speak up! To a lip-biting

pilot. The blast-No not the blast, the bang:

whichever! The stereo woofer snapped.

The silence that followed was deafening.

Zusha–doing nothing is not an option;

'Speak up, Silence is killing us!

Do not let a reckless driver make you end up like this!'

'Prevent an accident now. Speak up against reckless matatu driving.'

'If only passengers spoke up... speak up now while you still can!'

'Don't end up a victim of dangerous driving,'

'You have the power to slow down a reckless driver.

'Me I'll Zusha,

Be the passenger in the driver's seat,

even if it's not nobler- Haply be

Safe

[Between 3000 and 13,000 Kenyans lose their lives in traffic-related collisions every year. Kenya's 14 seat passenger vehicles are known as matatus and the drivers are notorious for speeding and reckless driving (www.zusharoadsafety.org). In December 2017 the Sachangwan 15Km- stretch of the Nakuru-Eldoret highway, 150 lives were lost in various almost 'concert-like' type of accidents mainly blamed on human error, and the 3 lanes single carriegeway. Plans were underway to separate the two into duo carriage-way].

Getting the relevant education on leadership and management would help the health care provider in assessing situations accurately, share fact-based information, and clearly articulate issues Health Sector Assessment 2010 report also attested to this need. But it is also possible that most performance problems cannot be solved by training alone (Rowe *et al.,* 2005).

In the closing remarks of the research brief and annotated bibliography coming up in chapter 9 the following begging questions concerning the provision of quality health care came up:

(1) How can we make our work environment safe for our patients, students and for ourselves?

(2) Lay care providers (including relatives 'caretakers'), whether they do assist with care or usurp nurses work, cover shortages;

(3) The congestion in the wards, patients sharing beds overcrowding and hygiene issues with wards, and what it means for staff; when can a nurse in a public hospital say the ward has a maximum number of patients and can admit no more?

(4) Can nurses "ration" care to cater for more patients, lower per-patient effort and still be consistent with higher patient welfare?

(5) At what point can we say that a hospital can no longer absorb more health related trainee students on attachment; (6) How can we make the nursing curriculum more user-friendly to the two most important clients- the student and the patient?

(7) When would it be alright to divert an ambulance because either we cannot take in any more or we are overwhelmed? (See **18 hours ambulance ordeal** in chapter 4).

The fact is: - Public hospitals are overstretched beyond the limit. The answer lies somewhere between the causes which might be poverty to less than prudent management of available resources. Interventions seeking to optimize the ratios of the nurse to patients should be comprehensive, as increases in nursing students recruitment will only be feasible if the limitations in clinical placements, faculty capacity, and physical infrastructure are simultaneously addressed. In one such hospital, this author observed that one nurse was on day duty with two Clinical Officer Interns and sixty medical surgical patients, there were a number of less than desirable episodes in a span of two hours.

A just organizational culture would focus on a safe practice environment where you could let your team know you are drowning, you cannot take any more. Accepting that 'No!' Is a full sentence in and by itself. Just culture would have research and support best ways to communicate your concerns. It should not wait for the worst to happen and then blame it on the individual health care provider who is giving direct patient care; many such are obviously system problems that no one is willing to label as such. In the foregoing there might be no such cushion that works as a stop light policy in most health care settings in Kenya, what then?

How does the stop light work? Best practices from Transforming Care at the Bedside Project (TCAB)[58] had the following colors: Red (drowning), Yellow (could get in trouble), or Green (all is good). TCAB is a project of Institute for Healthcare Improvement (IHI) and Robert Wood Foundation.

Any nurse can put themselves or others in a color so the team knows who need support. It is important to have these quality improvements because without established values, rules, and a culture that hold them in high esteem, employees will feel *like a sinking ship*:-

Titanic
…like a ship at sea. In turn, they will either go where the wind blows or make their own wind or do as they like. As in the famous retelling amazing true movie story about a luxury ship "The Titanic", recounted how the tragedy on April 14, 1912, happened on her maiden voyage with 1,500 passengers and crew '… after the Titanic hit an iceberg and continued to sink… the band played, and listened to the harp, and remembered how the camera spanned the pictures of Rose's rich life in love and adventure! ... and the band played on the deck and went down with the Titanic'.

Like this analogy of the ship: do we want to go down with the vessel (drowning) or launch a life boat and head for safer waters? Nurses, fortunately, must ethically choose the former, in the hope that they will ultimately be rescued. Pity about the ship (in this case; resource constrained settings) that lives one day at a time until another such or worse challenge comes up. Rarely are there proactive measures in place and if they do they are rarely tested and updated.

It was difficult to overlook the bumpy take-off of the health sector in The Constitution (2010) implementation, and it remains one great example that supports this line of thought. Just before the promulgation of the constitution health care professionals just like everybody else knew it was *On your Marks, Get set, Ready, Go*!. But were we set? …and ready - to go? The answer had been a resounding NO! For many health care workers they felt 'it was better while we waited' as late Kwame Nkrumah once said concerning post-independence Africa.

The reason why the aviation industry has become quite safe is because it was Ok to say you need help, that you cannot take any more, someone can jump in for support, or tell when your team was not having the best day. You did not even have to explain why. TCAB endeavors to link the quality of care patients receive and the work environment in which their caregivers function. The initiative was a response to growing concerns over the crisis in nursing.

Let us consider the following example from one hospital unit that tried this initiative. A white board in a central location on the unit with bright *red, yellow and green* magnets to communicate the rankings. Red for 'I'm swamped, I can't take another patient,' yellow for 'I'm almost there, just give me another hour,' and green for 'I'm ready for a new patient.'" The board caught on right away and was being adopted by other units in the hospital. What kind of workers other than compleat ones can have such integrity to use these? These are the kind whom you would allow to do self-scheduling of their shifts because they can be relied on to do the right thing. They would not take work flexibility as far (and away) as possible.

It had been observed that most nurses loved their work but had to battle fatigue. To ease this we needed to have nurses who had more control over work schedule, had regular breaks, adequate rest periods between breaks and access to health & wellness programs. Hospitals and health systems needed to invest in nurturing and supporting their nurses (Brooks, 2017). These values could be fleshed out and become a part of our verbiage in Kenya too. This may be an overdrawn picture of a health system that many seek and cherish but nevertheless continue to draw it.

[58]TCAB (http://www.ihi.org/resources/Pages/ImprovementStories/TransformingCareattheBedsideinitiativePrototypephase.as px(Linkstoanexternalsite.))

Unfortunately for our case, even some dire circumstances mentioned in numerous case scenarios in this book and elsewhere on Kenya's public healthcare setting continued day in day out as though it was Okay. Is it 'safe' to have more than four or five times the number of patients one nurse could take care of in labour ward? What makes our situation different, tolerable and 'normal' (see **The Night Coverage** below). What would it take to make that happen? The answer was very simple, doing nothing about it. A better answer would come if you asked - what would we do differently? We have a long way to go; it calls for one to be philosophical in dealing with some perennial challenges. Aristotle the Greek philosopher said, 'What we have to learn to do, we learn by doing'.

Construct No. 6; therefore, is about tying all the other five constructs together. It is related in a unique manner to each and every one of them, looking at the gaps in each and all of them and Building bridges. First and foremost by employing an introspective approach as a basis for thinking outside/or out of the box. Some discussion on thinking out of the box will be just before we come to the end of this chapter.

That is why at the risk of appearing simplistic; this author chooses to tie up the constructs by echoing the words of some icons that have inspired his thinking over time (see **Point to Ponder** below):

Point to ponder

Start by doing what's necessary, then what's possible, and suddenly you are doing the impossible-Francis of Assisi (1181-1226) and Whether you think you can, or think you can't, you're right –Henry Ford (1863-1947).

"I can't do it" never yet accomplished anything" I will try" has performed wonders- George Burnham (1868-1939). *Nothing will ever be attempted if all possible objections must first be overcome* - Samuel Johnson (1709-1784) Closer home, Dr. Geoffrey Griffins (1933-2005), Kenya's renowned educationist and founder of Starehe Boys' Centre said this, "*This world is full of people who do their duty half-heartedly, grudgingly and poorly. Don't be like them. Whatever is your duty, do it as fully and perfectly as you possibly can…"*

Patty White, BSN, MSN, CEO of St. Joseph's Hospital and Medical Center in Phoenix *"Do the best job you can in the job you are in. Let people know you want to do more*".

Jason Bourne the main character in Robert Ludlum's (1927-2001) thriller 'The Bourne Supremacy' fondly applied the saying*: …look around; there is always something to use.*

Caveat: This author does not at any pont advocate for using hospital equipment or stuff for purposes the manufacturer intentend. It could cost a patient's life… but then, someone might argue he could if you don't. Always remember the licence is yours to guard, and so passing on the blame to others/circumstances would not work. Neverthelss in poorly resource settings some ingenuity was needed more often out of necessity.

The constructs in Best Care Anywhere Organizing Framework for Resource-Constrained Settings (BCAOFR-CS) envision a responsive health system characterized by:

- Speed and timeliness of delivery/punctuality;
- Courtesy and helpfulness;
- Service reliability;
- Consistency in service delivery;
- Accuracy of paperwork; Positive attitude from staff;

- User-friendly systems/less bureaucracy.
- Its functionality will become evident through Access to services;
- Quality of care and service delivery;
- Safety;
- Coverage;
- Equity;
- Efficiency;
- Effectiveness of health care delivery;
- Ethics, and rights-based approach in the delivery of services and
- Sustainability of services.

Changing the future will require that people look beyond their immediate self-interest to view the common good of a healthcare system that is accessible, affordable and of high quality.

A heightened level of public discourse will be needed, as the citizens are better informed and more actively engaged in shaping the future of the Kenya they want. They would want to connect this aspiration with their daily realities. The needed leadership, attitudes, actions and foresight of care providers will play a major role in determining the future of health care in Kenya. Conducting a Root Cause Analysis or a Failure Mode Effects Analysis needs to be adopted as an organizational culture for quality improvement to prevent recurring (previously experienced) problems, mitigate those occurring, and pre-empting those unexpected ones occurring in the future.

We can barely afford to bask in some past glory of some success stories because it is hardly part of the reality of health care in our setting, such stories are far between and amidst deprivation. This is not to say we cannot learn from our past mistakes as well as successes. Indeed one of the characteristics of successful health systems was that they were resilient, learned from experiences that fed back into the policy cycle. Achieving the Best Care Anywhere is such an admirable but elusive goal. One that we must seek if haply we might feel after it and find it, though it is not far from every one of us. After all it's been said that chance favours the connected mind, while fortune favours the brave.

6.0 Strengths

- It guides users into self-reflection and inquiry on values and professionalism in assessment of barriers and facilitators to quality health care; it may potentially stimulate theoretical insights, encourage competing ideas, discussion and debate.

- Its scope can be adaptable to cover other services apart from health care delivery, and in cognizant of this it uses generic terminology that is sufficiently amenable to be used in service delivery sectors outside health care.

It is an advocacy framework which is realistic and easy to relate to, highlighting ○ the interests of the consumers as our core business even in resource-constrained contexts. In this regard, health care providers of all backgrounds, specialties and education levels can become leaders in their communities and beyond. Their voice
in transforming lives and fortunes matters.

- Can be used by individual practitioner, teams, leadership, and organizations to enhance decisions on patient and system outcomes.

The Night Covering

The night covering nurse is one who takes charge of the whole hospital after normal hospital business has closed. That means from around 6 or 6.30pm to the following day 7.30am, but when you include the 1 to 2 hours of handing over the report to the bosses he or she leaves the hospital between 8.30 and 9 pm. He or she faces myriad challenges and acts as everyone and everything at the same time. From supplies officer to transport officer to chief records officer, name it. The rest of the hospital assumes so to speak that problems will sort themselves out at night. Or that the innovative nurse covering will figure it out a survival solution somehow. Policies and protocols are inconvenient, are meant for another time, not at night.

Every other on-call fellow can sleep in their houses no matter how far away from the hospital and wait to be called. Some were known to be *mteja hapatikani kwa sasa, jaribu tena,* Kiswahili for the subscriber cannot be reached, please try later, may be they even switched off their phones, *please leave a message* on the answering machine was equally ineffective. All this while the nurse covering armed with a pen and a notebook, a walkie-talkie, a mobile phone. She will be lucky if she has anyone else to keep her company for the night walk in and out of doors, floors, into dingy stores to check for this or that out of stock urgently needed item. She has a pile of requests to meet from the floors, a lengthy report to write and several emergencies to salvage.

Come morning, she hands over the hospital to the bosses and the day drags on. One veteran shared that the problems she handed over many times remained unattended even though everyone was there to solve them problems. They either were handed over back to her in the evening or if she was unlucky she stumbled on the very same problem untouched the same night, the status has not changed. These range from simple maintenance jobs like lighting to oxygen, to patient in need of an 'urgent senior review'. My informer continues I remember there was this one light in the Casualty Department offloading bay that we discovered did not work every night,lol!, maybe it's still a bit dark even tonight. Seemed No one remembered to check on it during the day ever since. (lol a colloquial form of laughter, here used as antonym for sarcasm)

Anecdotal evidence showed that this seemed the order of things from one hospital to another, for many staff that is all they have ever known, period! Up to when or should we say since when will our public hospitals continue to work 8 -12 hours and not 24/7 business hours. All the good we achieved during the day slides back several points at night. Near miss and cardiac arrest situations with a fair to good outcome change to POOR at night. Slow codes, subversion, rule bending…colluding or premeditated acts of omissions resulting in poor outcomes (including a patient's death) I am afraid to have been known to occur if not for any other reason but because it is at night. Then she remembered the (not so rare) dismissive comment - Who will go looking for this and that at this hour of the night?

- Kenya was widely expected to fail to meet the United Nations' Millennium Development Goals (MDGs) for health (we are already there anyway). This year 2015 marks the deadline in which all countries should have met all the Millennium Development Goals (MDG) that the world committed to in 2000.

  Of the eight goals, Kenya had underachieved in Number Four, reducing child mortality, and Number Five, improving maternal health. As a signatory to the Millennium Declaration, Kenya had been structured many of its health and development programs around the Millennium Development Goals (MDGs) and currently Strategic Development Goals (SDGs). Lessons can be drawn from highlighting instances of personal experience and achievement with wider implications for policy makers in Kenya as an alternative and important path to improving standards of care.

- This could be a strength and possibly a weakness: Instead of building a full-fledged predictive model, I have tried to make a good enough model as a prototype that is easy to relate with and test in the local settings.

6.7 Weaknesses

The weaknesses of the framework include:

- It was not possible to gauge how many staff at the operational level/point of service ever applied any model, framework or standards, protocols, decision support or even clinical guidelines on a daily basis or at every turn of events.

- The major weakness is that it asks questions without necessarily suggesting solutions, therefore may appear to be simplistic on issues such as professionalism, equity, compassion, advocacy and client empowerment.

- Constructs are framed in first person singular/plural which might appear opinionated or subjective by some users.

- The constructs are not as succinct, steps cannot be explained in as few words as possible

- Some constructs could be left out with little or no effect on an overall study that would choose to apply this framework. The choice of which construct(s) to pick are on a case by case basis. Some studies may not necessarily apply construct No. 3.

- It envisages a compleat health care provider/team, having the qualities needed to perform in resource-constrained settings. This would be a rare axiom (not a self-evident truth) since it is not established or supported in previous research. The number one problem in health care proposed in this framework is having someone (s) who can see to it that each patient gets proper care. Every patient NEEDS an advocate for his (her) care, someone who is competent, knowledgeable and willing to work at it.

- It is being published for the first time and so research to support the relationships depicted in the framework are untested empirically and also it is yet to be used to generate hypothesis. Its first use as a quality indicator was in a study 'Walkthrough survey of acute rooms at Levosix Hospital in 2013.

- It was not always possible to be objective; somehow the communication of the framework includes some part of the author's personality.

6.8 Intended users

The following were the intended users of the framework:

- As an issue brief to programs run by the Ministry of Health and agencies in health in Kenya implementing Kenya Quality Model for Health (KQMH) 2011 and Kenya Health Policy Framework (KHPF) 2012-2030. Organizations can also use it in customer care as a quality indicator. Regulatory, accrediting, professional and statutory bodies might find it useful. The constitution 2010 provides for the Bill of Rights, in which Kenyans are entitled to access quality health care and we must endeavour to meet these aspirations by the society. The 2010 constitution implied drastic changes to health service delivery and management by guaranteeing the right to health and devolving health governance to 47 newly formed counties,

- Individuals at point-of-care/service delivery can use it to self-regulate and step up practice. At the individual level it recognizes that small gains have a positive impact toward quality service/care, what matters is that they become more regular or continuous, even during such distraught times as this one; *Dear Samaritan, I am a health worker working all alone in a small rural dispensary run by a local church…*(CHAK, 2013). In the spirit of the African proverb - *the sun does not forget a village because it is small.*

Such peripheral staffs have been left to their own devices and 'standards' to make the best of each situation with no backup support they can summon in. Several 'rurals' as they were popularly called operated with only one staff, dispensaries had to close down and remain closed whenever the staff went for training, monthly meetings at the sub-county, went for vaccine or drugs. Many such staff did not get someone to relieve them and would have to forego their annual leave many years in a row.

- A number of providers just don't want to work in those higher-need areas for whatever reason. What do we do if an area can only attract one or two providers? Some areas are struggling to even have one provider. I have heard of staff that threw a tantrum or fell sick to avoid certain geographical practice areas resulting in communities with poor access to care. Incentivising healthcare providers to practice in less appealing areas might be the way to go. Incentives should be targeted to low volume isolated providers who are at a distance from other providers.

People who stay in the area longer and develop great relationships with the patients they serve. A context check on the workplace in a fair number of resource-limited settings, while they may at times appear sublime, are also hostile or at best indifferent to health care providers and patients alike.

Adjusting to the extent for factors that are beyond the provider's control, some areas may not qualify for hardship allowance by previous standards, but nevertheless, deserve because they are undermanned and underfunded. The lack of funding and reward for people who take upon this cause is discouraging since every healthcare worker would prefer an easier lifestyle to this. It is easier to talk a good number of them into a more lucrative high volume rich insurance area in towns and cities of Kenya than about rural healthcare.

- Reaching out to the proprietor of 'Kalumaido'(fictius name) private clinic somewhere in the bush or deep in the slums, these informal outfits are otherwise referred to as 'Kiosks'. The more formal ones *Afya-kiosks* are run by The Center for Health Market Innovations (CHMI) which promotes programs, policies, and practices that make quality health care delivered by private organizations affordable and accessible to the world's poor.

- Nurse managers striving to rise above the challenges and demands placed upon them in a changing work environment will find this framework useful. Some of the biggest issues in nursing for example could be addressed by focussing on creating a healthy work environment. The maiden framework was cited in studies by Kamau (2012, 2013 & 2014).

6.9 Limitations

The following were the limitations of the framework:

- Since this was a review document summarizing on as much of secondary as primary sources, it would rarely be possible to achieve complete objectivity. We all perceive the world through the contemporary prejudice; in this, this writer was no exception. Every effort was made to control biases, through reflexivity journaling on the author's values as pertains what he considered to be quality health care or the compleat health care worker.

The reflective journal contained observations on ways the author and others operated in a variety of work and social situations. Some of the field notes documented observations of own professional experience, attitudes, skills, practices, and communication in an interpersonal, a team or group, and an organizational context.

- Awareness is increasing that medical care alone cannot adequately improve health overall or reduce health disparities without also addressing where and how people live. Health is influenced by a wide range of factors, many of which fall outside of the health care delivery sector. According to Braveman *et al* (2011), the health of an individual or a population is influenced less medical care than by broad social-economic factors. These determinants of health include, for example, several characteristics of how people live, work, learn and play.

Decision and policy making in areas such as transportation, housing, and education at different levels of government, and in the private sector, can have far-reaching impacts on health. It would have been good for the framework to recognize the influence of Political, social, economic, and cultural factors that affect the services health care workers provide and the care their clients are able to receive (Braveman, Egerter &Williams, 2011).

- It might lead one to feel that this book failed to recognize that the majority of problems leading to poor quality health care in Kenya are created by systemic organizational defects beyond the control of the individual health care provider, who in the first place may not be in a position to command resources but is blameworthy.

The scope would be too wide for any one book to cover all these. The underlying determinants of the right to health, such as adequate housing, food, clean safe water, social security, and education, are also guaranteed in the Constitution 2010. There is need therefore to apply a health lens to decision making in non-health sectors.

- Whereas organizational issues have been addressed by various models and frameworks discussed in Chapter 4 & 5, the aspect of the care provider's role still requires more input. For example, it is a fact that a health care provider, even a compleat outstanding one can only do one thing at a time (see **Networking helps** below):

Networking helps

Some of my network nurse friends shared the following:

We use a MESSSI board. We identify problems that failed in the last 24 hours or that we anticipate will fail in the next 24 hours. We discuss problems with Methods, Equipment, Supplies, Safety, and Staffing, and then we give Information (MESSSI) such as shout outs, what's working well, announcements. After problems are identified they are categorized based on when they can be fixed (today? this week? 3 months?) and someone takes ownership of the project. The owner then coordinates the solution. Big p rojects or (A3) projects go to committee. The A3 concept is explained in these links http://a3thinking.com/faq.html, http://leanhealthcarewest.com/Page/A3-Problem-Solving. What we've found though is that through the daily management of problems we have fewer A3 projects.

Similarly, we have a daily safety briefing where we are able to discuss, department by department, any patient safety concerns that have come up in the past 24 hours (or since the last call). It's also a forum for us to mention any equipment or supply shortages we have encountered. It's been in place a little more than 2 years now and has really been adopted by the organization, management, and staff.

We informally use your MESSSI framework, just without the fancy name. We implement a similar model at my job. It is a great way to motor problems in "live time," which gives the team an opportunity to implement change that can actually prevent the identified problem from worsening and/or happening again

This author was not convinced a lack of caring was always the issue, though we cannot entirely rule out loving and humane care as a missing link in nursing. Infact caring is the essence of nursing and is the basic factor that distinguishes between nurses and other health professions. Nursing icons like Jean Watson's even came up with the *Theory of Human Caring*.

The staff (nurses and others) recognize that they were no longer the only a source for patient information but also they are the most important source of support and comfort. Caring includes behaviours such as respect for the others, assurance of humanistic presence, positive communication, professional knowledge and skills and attention to the experiences of the others.

Caring is an interpersonal process that is characterized by expert nursing, interpersonal sensitivity, and intimate relationships. Yet patients' satisfaction from caring behaviours is very important (Azizi-Fini *et al.,* 2012). What if it was not possible in the circumstances for these to

adequately develop, if at all? Rather, I think that increasing workload demands and responsibilities combined with increased nurse to patient ratios in many parts of the country are affecting perceptions of caring. After all, when you're exhausted and trying to do a million things at once, it is hard to quickly respond to requests or to spend the kind of time with patients they expect.

The nurse in modern day Kenya has found ways to shave time to save time. That even the best of effort is only a singular contribution to the journey for the greater good that we refer to as quality health care. For example, if six patients in a 42-bed Nyayo ward were to press their bell(s)-(where there are some) at the same time and there was only one nurse on duty (as is sometimes the case), five may not be answered (see **Patient fall** below).

Less time is spent getting to know the patient outside of the diagnosis (both medical and nursing). Even then, a diagnosis is a match in constellation of findings observed in a person to patterns that have been shown to cluster in patients, respond to treatment in a comparable fashion, or have a common cause. Findings and responses can be shared among diagnoses and multiple diagnoses co-exist in one individual.

The nurse involved in the fall relied on the organization with which she identified to support her as she followed procedure, taking responsibility for her actions and opening herself up to the follow-up process. The private information became accessible to many others as the nurse trusted that the ultimate benefits to the hospital would outweigh the risk she took in sharing the details of the incident. It was a conscious choice to do so. With such a reaction in the case study- **Patient fall**, the RN would certainly understand if such incidents often went unreported by nursing personnel (see Iowa model application). But there was obvious disincentive in the outcome.

The nurse should have been acknowledged for coming forward to explain the incident of the fall. This might explain why correct knowledge often does not predict correct performance. Looking at the patient's point of view too might help - the patient feels he owns you. He as well his relative (just as other patient relatives in the wards) also believes that you should abandon others to give them full attention.

Patient's fall

In one lawsuit, a case from one of the developed countries, the nurse had been one arm's length from the patient when the patient fell, according to hospital falls protocol but the manner in which the patient fell precluded the nurse from catching or stopping him. The fall in a bathroom could have been a hypotensive episode. He fell, struck his head, a CT scan revealed a big cerebral bleed with a hematoma forming; this had necessitated an emergency craniotomy, healed with complications. In the initial sittings in the courtroom cross-examiner began by asking the RN if she was familiar with the hospital's fall protocol. He read from the protocol, announced to the nurse that she had "deviated from the protocol" by failing to stay within an arm's length of the patient. The nurse replied to a repeated question: "The nurse was an arm's length away? ("Yes.") An arm's length away? ("Yes.") And still, the patient fell? ("…yes…")" Looked around the room, soliciting support, and obtained a few muted grunts and nods of the head. "Well, it seems we have some sceptics here. We're going to have to look into that one again." To which the RN replied with a subdued, "OK…" The hospital paid the patient an equivalent of Kshs 20 million. This was said to be one of the mildest compensation that took into account fairly good staffing levels, after concluding that it was purely an accident and not as result of an omission on the part of the nurse...T.L posted in *Africa Health Report* August 2018: 'In the area of numbers of care providers - If there are only two nurses to attend to 200 patients, the two cannot multiply themselves and make you wait less because yours is an emergency. A nurse cannot cure absence of drugs or lack of an ICU bed except if they had failed to act on time' [https://articles.africahealthreport.com/2018/08/31/our-hypocrisy-is-the....].

A charge of negligence against a nurse can arise from almost any action or failure to act that results in patient injury-most often, an unintentional failure to adhere to a standard of clinical practice-and may lead to a malpractice lawsuit. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) *defines negligence as a "failure to use such care as a reasonably prudent and careful person would use under similar circumstances."*

The concept of discipline relies largely on pressure from the group (peers) exerted on non-conforming members. It has to do with the pride employees take in their organization and its work. Were this RN to encounter a similar situation in the future, how do you predict they would react if all elements or the system remained the same?

How might this whole matter translate in our Nyayo ward scenario just above? Such an incident would more likely go unreported in resource-limited settings because (I suppose) safety was less of a concern to many of us and therefore it didn't matter. But more importantly it would rarely be treated as a system issue and *itakuwa ni kama kujistaki*, Kiswahili paraphrased to mean one would be putting themselves into more trouble by owning up. This, however, should not cross the bullying line.

Bullying: Uncivil behavior from someone who has power over you. Bullying behaviors create a toxic work environment which not only harms nurses but also our patients. Experts agree nursing communication breakdowns and lack of teamwork are a root cause of errors. From a very ethical perspective, tolerating bullying behaviors is wrong and violates our basic oath to keep patients safe.

Overt bullying or incivility included - name calling, bickering, fault finding, criticism, intimidation, gossip, shouting, blaming, put-downs, and raised eyebrows. Whereas *covert bullying* might include - unfair assignments, refusing to help someone, ignoring, making faces behind someone's back, refusing to only work with certain people or not work with others, whining, sabotage, exclusion, fabrication Source: 'Lateral Violence in Nursing Breaking the Spell' by Bartholomew (2017).
Murphy's Laws of Nursing Infographics is a blog that nurses shared their diary of the realities They wentthrough. It was forever being updated with new *laws* available at http://blog.bestnursingdegree.com/murphys-laws-of-nursing. Some of these concerns were discussed in the research brief and annotated bibliography on nurse: workload assignment in Chapter 13.

The following posting on the Kenya National Union of the Nurses Union of Nurses (KNUN) wall on social media spoke loudly about the dilemma these nurses faced amidst double standards in terms of quality in the Kenyan health care system. N. F on January 18th, 2014 posted Facebook wall:

> *'Why admit 20 mothers in maternity ward if only two nurses are on duty? We have ourselves to blame! To avoid such a mess let's do our work carefully and provide holistic care to only the required number of patients... like private hospitals do?' Another one wrote, '... reported nights, nurse to patient ratio 1:60, how am I expected to give holistic care?'*

Caveat: While the postings above were a reality and held some truth, a patient cannot be turned away from a public facility even if the wards were occupied beyond capacity. This would be unethical and against the Bill of Rights in Kenya. A lot of understanding and patience would be required from all concerned since it was a situation beyond the health care provider and the patient, to make the most (or the best) of the given circumstance, Best Care Anywhere framework though not providing for exemptions is not ignorant of these difficult circumstances.

Managers should understand what encourages their staff working in such settings, encourage them to give their best and endeavour to address what causes disillusionment. These could not be addressed in this framework. An attempt to think through this is found in Gallup's Managing for strengths in Chapter 14. An outline is also available in Appendix XIV.

6.10 Future: How the model can be applied and plans for revisions

The BCAOFR-CS has its place now and into the future in that:

- It addresses an on-going concern of all times - quality health care and is in a continual state of development as new evidence emerges which may challenge and augment the constructs.

- It encourages efforts that may be small but solve real problems for the health care worker(s); as a way to introduce small do able, focused initiatives even when resources are in short supply.

- Provokes the indulgence of diverse audience in addressing pertinent questions that the author believes affected access to quality of service delivery in various settings and not just health care. Therefore its application can be broadened.

- Disturbs the status quo jostles for positioning of transformational leaders.

- Nurtures reflective practice, support cultural shift in each one of us even as we endeavour to offer the best service possible to our clients in the area of our calling.

- It envisions that: Articulating/focusing/framing the questions into key constructs might increase the likelihood of finding appropriate evidence to answer the question. That a level of dissemination will be achieved by having an 'accordion style' pocket guide of BCAOFR-CS incorporated into KQMH and KHPF for everyday use.

- It is hoped that its usefulness will be tested further and generate research to validate/support the logic and intuitive propositions in the BCAOFR-CS framework. Since it is an assessment of barriers and facilitators to quality care it may potentially stimulate theoretical insights.

- Each of the constructs can further be developed independently or with another e.g. 'continuous supply of basic cross-cutting supplies and equipment' or 'quality health care in every setting.' These can also be looked at in terms of narrowing down to specifics like maternal health care, child health or adolescent health. The Kenya Health Policy Framework 2012-2030 section 2.4.1 talks about 'Ensuring equitable allocation of government resources to reduce disparities in health status', while section 2.4.2 'Increase the cost effectiveness and cost efficiency of resource allocation and use'. Efficiency means distributing funds to where they are needed most, minimizing waste along the way, and ensuring value for money. Both sections, however, fall short of showing how this should be done.

6.7 Implications

The health care sector will have to become more adept and sophisticated in discerning and pursuing activities that substantively contribute to increasing access and utilization of quality health care and other performance goals. This evolution will require increased sophistication on the part of hospitals to optimize available resources to carry out their work. The central government, county governments as well as healthcare organizations will face growing tensions and trade-offs when it comes to allocating resources among the many competing priorities: development, direct patient care, quality improvement and other important activities.

Access and utilization of quality health care is not solely the domain of health care workers, though they were the main focus while developing this framework. The truth is; they can only go so far if they stretch themselves to a certain limit. However, what this framework sought was to embrace the personal obligation to participate in improving access to quality health care from the outset. This gap was found in many models and frameworks reviewed since they tended to look more into the major stakeholders like the government and non-governmental actors sort of leaving out the individual health care workers.

There is need to guard against diminishing the involvement of health care workers. With dialogue and consultations quality improvement activities were likely to have the greatest influence and impact. Involvement should not be cosmetic, whereby they felt they were just there to be seen, it is necessary to know what exactly their input was. They are integral to these activities because of their day-to-day patient care. One way out seemed to be to encourage the individual health care providers (especially those in the lower and middle level) that they were not mediocre participants in the health care industry but proud owners of the quality management processes. I feel that more than systems, the basic units of these processes are and ought to be – people... who may 'fall through the cracks' in an ever widening scope on what they were expected to do with each emerging framework/model. Annette Eichhorn-Wiegand, a Quality Health Management Systems Advisor with Christian Health Association of Kenya (CHAK) had observed that (see **What does everyone want?** below):

What does everyone want?

Different stakeholders lay emphasis on different kinds of evidence. While donors preferred international evidence and Ministry of Health (MoH) officials looked to local evidence, district health managers preferred local evidence, evidence from routine monitoring and evaluation, and reports from service providers. Service providers, on the other hand, preferred local evidence and routine monitoring and evaluation reports whilst researchers preferred systematic reviews and clinical trials. Stakeholders preferred evidence covering several aspects impacting on decision-making highlighting the fact that although policy actors look for factual information, they also require evidence on context and implementation feasibility of a policy decision.

[Adapted from: Nabyonga-Orem, J., Mijumbi, R. (2015). Evidence for informing health policy development in Low-income Countries (LICs): perspectives of policy actors in Uganda. *International Journal Health Policy Management*. *4*(5): 285–29].

The approach of many of these models was also too formal to relate to the common care giver. The KQMH, for example, might be too bulky and complex for the average health care provider in Kenya. CHAK Times dedicated a volume [January-April 2013 edition] to dissemination on quality health care.

Characteristics of the workforce, the settings in which they provide care, the nature of their work, as well as the implications of these elements on quality of health care need to be considered. These apparently have a reciprocal relationship, each influencing the other in an ongoing, dynamic interplay. Concerning some of the challenges in these resource-constrained settings, there will be no immediate answers, it's a matter of mastering the situation, and their solutions become a matter of strategizing, timing and perseverance.

The bottom line is that all stakeholders must fulfil their obligations of creating healthy work environments where access to quality health care becomes the norm and excellence the goal. It especially calls out to national and counties' attention to the urgency and importance of equitable access to quality health care. According to President Uhuru Kenyatta '…the one goal we share is how soon do we get there?'

A stake holders seminar in June 2013, recommended that, 'Charting a solid way forward for Kenya will involve developing a broad framework that outlines the vision for the health sector, keeping in mind the new constitution and new legislations that are being created and addressing issues such as subcontracting, regulatory bodies, etc…'(Technical report, 2013).

KQMH and KHPF apparently were not linked yet they address critical issues of the country's health care system policy and quality. Another example of a critical stakeholders' *Health Sector Intergovernmental Meeting Consultative Forum, Summary of Discussions* on 27-28 October 2014 Panafric Hotel, Nairobi [59].

This chapter concludes by touching on a small aspect that has to do with critical thinking. First, I am student of critical thinking that brought forth 'Think out of the box' that encourages us to think differently, unconventionally and with a new perspective (akin to generating wild ideas depending on who it is that teaches you this concept). What I have an issue with is that it discourages thinking of the obvious, it emphasizes that we must look beyond.

It was the feeling of this author that new teachings on thinking outside the box might have left the health care provider feeling that solutions do not come from within; perhaps removed the actors in health care from the reality of the fact that in more ways they would be willing to admit, they are as much the product of - as well as partakers of the very health care they provide. They might as well be the cause or part of problem or are the problem themselves. The converse may also be true that they may be part of its solution or are the solution themselves.

The late Chinua Achebe was quoted saying, *"People say that if you find water rising up to your ankle that is the time to do something about it, not when it is around your neck."* They should be willing to change (or be changed if this were possible) gradually but more important the gains must be sustained.

[59] October 2014: Intergovernmental Meeting, Summary of Discussions
http://www.healthpolicyproject.com/pubs/782_HealthSectorInterGovernmentalCosultaALNov.pdf

This book envisions a paradigm that begins somewhere by peeling the bottom of the box first. Situating ourselves in the known, frank, insightful re-appraisal of the situation, oneself and the organization on the obvious or not so obvious and speculating what might happen next, then managing the progress. James Bandrowski (1990) described both inside the box and outside the box. He had observed that some people should be outside the box but were still inside it while the opposite is true; that others were claiming to be out of the box while indeed they were inside it (out of the box when they should be in it).

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CHAPTER 7
Testing the Framework

A Walk-Through Survey of Acute Rooms in a Levosix Hospital in Kenya

Overview

This rapid appraisal study tested some aspects of the Quality Health Care Organizing Framework for Resource-Constrained Health Care Settings in Kenya (QHCOFR-LS) in its sunrise days. Indeed it was the first time that the framework was used to plan and execute a study. It guided the conception, drawing a checklist, data collection, analysis, and reporting. It addresses issues of disparate resource allocation, staff attitudes among others. Its propositions were explored with intention of stimulating reflection, inquiry and new insights on access to quality health care.

Each of the constructs posed some begging questions and decision points in the study. It brought out questions for weighing and considerations. Questions that may not have had immediate answers but which corporately were thought through into recommendations. Critical Care Unit (CCU) and Intensive Care Unit (ICU) are synonyms for the purpose of this study.

7.1.1 What informed the need for the appraisal?

There was a need to survey the acute rooms in the hospital as they continued to act as step-down facilities for the patients discharged from Critical Care Units (CCU) and High Dependence Unit (HDU) had a role in ensuring continuity of care for these patients. Access to CCU/HDU bed continued to be a big challenge in resource constrained setup thus there was a need to interrogate the quality of health care provision in the acute rooms.

CCU staff felt these were their patients, and made it their business to know how they were doing before, during and after CCU. A typical room (including acute room) in this hospital measured about 20 feet squared, fitted with six to eight beds. Due unrestricted admission and bed sharing it was not unusual to find 10 to 12 beds would be squeezed, thanks to bed sharing 20 plus patients would at times found in one of these cubes/rooms.

7.1.2 Special Considerations for the appraisal

-Observe and document the capacity of Acute Rooms to handle patients discharged from CCU/HDU

-Observe and document the capacity of Acute Rooms to handle acute & critically ill patients from within the wards.

-To Analyze CCU Quality objective to reduce mortality of critical-care-related patients to 40% or less by end of June 2013.

7.1 Historical Facts

Mortality in the wards after a Critical Care Unit (CCU) stay was considered a quality parameter and was described as a source of avoidable mortality. However, mortality in the wards after CCU discharge mainly affected patients with very poor prognosis according to the subjective perception of CCU clinicians. Quality improvement in this area may, therefore, be restricted to the population with good prognosis (Fernandez, 2006).

There was a risk of increased mortality in certain tracheotomies patient groups who were discharged to a ward after CCU as noted by Paul, (2010).

7.1.1 Why the Acute Room?

According to Chipps *et al.,* (2017) acute care hospital environments provided excellent settings for clinical nurses to conduct research that aimed at improving quality and patient safety. In the US Magnet ® recognition was one approach frequently used to develop a culture that promotes robust scientific inquiry among nurses.

It would not be in the best interests of all patients to be admitted to CCU; instead optimizing ward care, end of life or even palliative care was required. Critical care was a high value, labour intensive service meant to support failing organ systems where there was a potentially reversible disease (Cooper, 2003). The benefits and limitations of what was available in the CCU may have been poorly understood even from within the same hospital.

Patients with acute reversible disease…benefit most from intensive care if they were admitted sooner rather than later. Suboptimal care before admission to CCU increased mortality by around 50%. CCU mortality was doubled if the patient was admitted from a general ward rather than from theatres or the Accidents & Emergency, added Cooper (2003).

7.1.2 Document Review

A situational analysis another level six hospital carried out on resuscitation capacity in the wards by C&W (*nd)* recommended:

Neurological observation charts (e.g. Glasgow Coma Scale); Primary Nursing care; Suction machines + catheters; Oxygen flow meters; Facemasks & nasal prongs; Airways (adult and paediatric); Endotracheal tubes; Ambu-bags; Portable defibrillator; Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) skills, knowledge and training

7.2 Approaches utilized

Utilized rapid appraisal approach of a chart review of primary data and a survey to assess basic cross-cutting life support tools available in the acute rooms within the hospital. Utilized the Best Care Anywhere Organizing Framework for Resource-Constrained settings (BCAOFR-CS) as a conceptual framework to guide the conception, draw a checklist, data collection, analysis, and reporting.

"Walk-through"

A preliminary survey sometimes called an observational survey, involves a walking tour of the workplace (hence the more descriptive name, "walk-through").

“Walk-through” requires knowledge of the operations and structure of the organization and work habits of the population Menard et al (1986) and Chipps *et al.,* (2017).

Walk-Through Surveys

Benefits:

Quickly obtains an overview of the whole environment as a cross section.

Limitations

Possible observer bias (minimized through training of data collectors)

Possible lack of representativeness of observations

7.2.1 Walk-Through Tools

A checklist (simple enough for the research assistants to fill)

Observations

A guide may be necessary for unfamiliar places

Ethical considerations

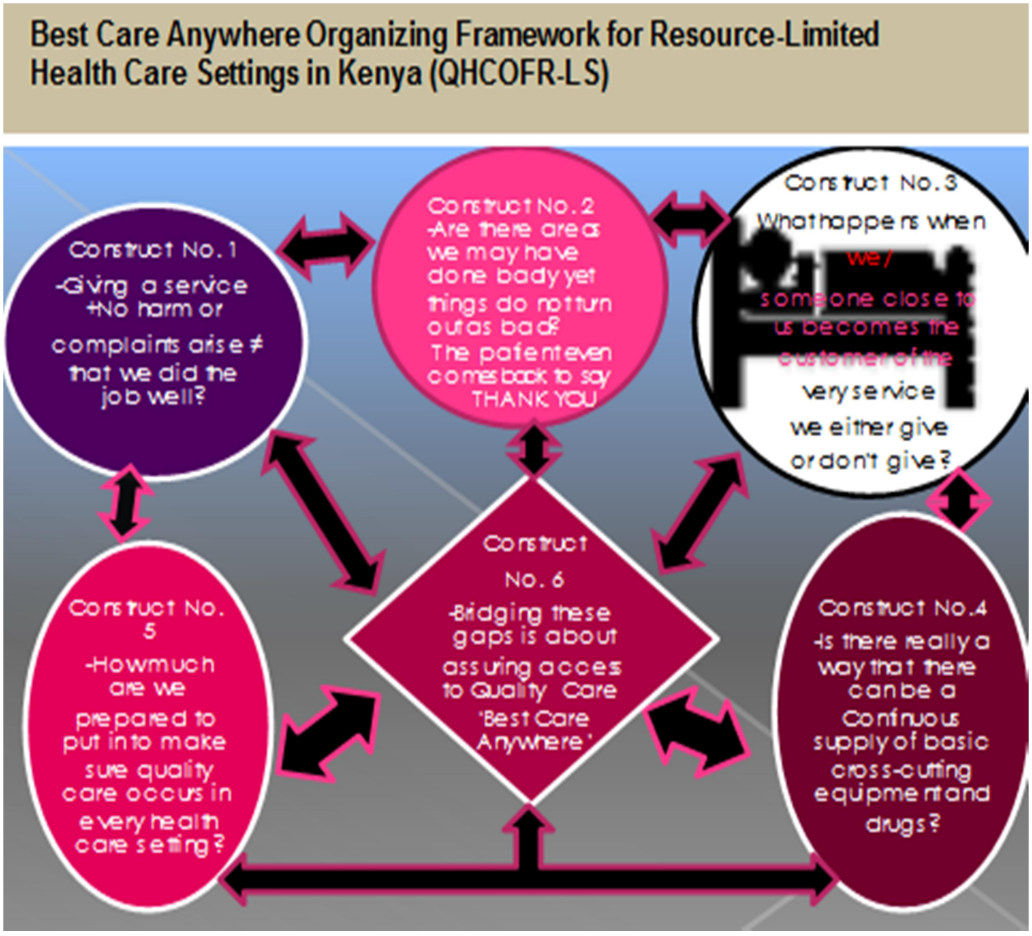
Permission to conduct the survey was sought from the office of the Chief Nurse under the Clinical Research and Nursing Audit.

7.2.2 Targeted Sites

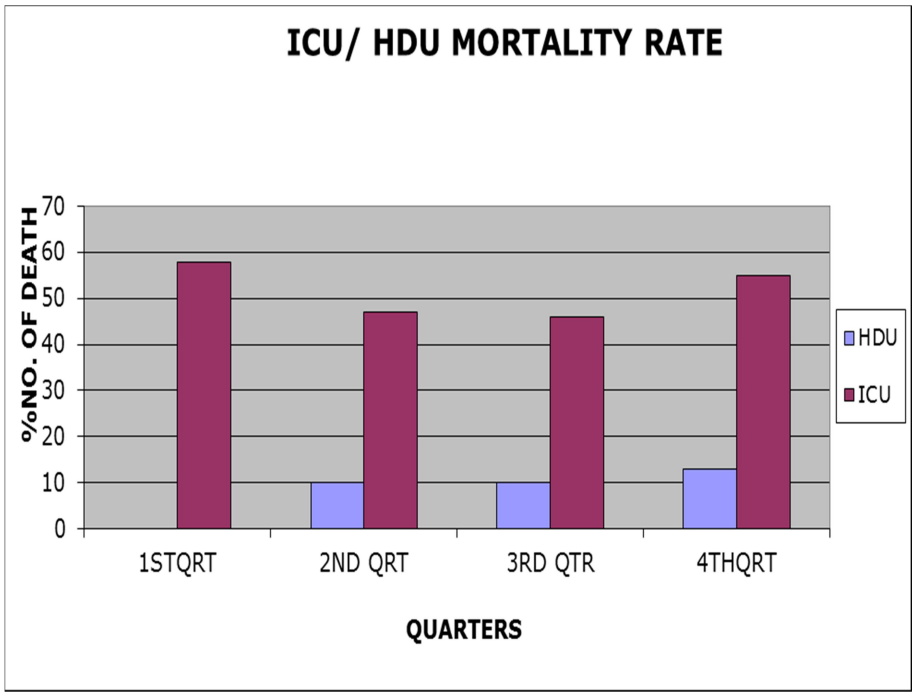
Conveniently selected likely step-down units (13 in total) for patients discharged from CCU were selected. The study was carried out on 23.07.13 between 11 am -1 pm.

The renal unit was not included due to some similarities with CCU/HDU. Accident & Emergency and the Operating Theatres were also excluded as unlikely step-downs for CCU, though they did admit to CCU.

Selected Wards; these were all coded with alphabets M to Z not necessarily in ANY order above for ethical purposes



(Source: Interrogating Health Systems in Resource-Constrained Settings Frameworks for Quality Health Care in Kenya, 2018)



Source: CCU/HDU Records

There was a decrease in mortality rate for CCU in three-quarters i.e. 58, 47, 46 and a slight increase in the 4th quarter i.e. 55 deaths per hundred discharges, while an increase in HDU deaths was reported in the 4th quarter. The graph below illustrates the trends in mortality rate for the two wards.

Table: CCU Mortalities since admission Jan-July 2013

Duration from admission	No. of deaths
<=24 Hrs	18
2 Days	10
3 Days	8
4 Days	4
5 Days	5
6 Days	3
7 Days	1
8 Days	3
11 Days	1
17 Days	1
60 Days	1
Source CCU Records	Total = 55

Table: Post CCU Discharge Patient management outcomes Jan –July 2013

Post ICU Discharge ward	Post ICU patient discharges home from ward	Post ICU Patient Deaths	Total
P	4	2	6
R	10	1	11
S	1	0	1
T	0	1	1
U	2	1	3
V	2	0	2
W	1	0	1
X	4	0	4
Y	1	0	1
Z	1	0	1
Q	2	0	2
M	8	1	9
N	2	0	2
TOTAL	38	6	44
	86%	14%	

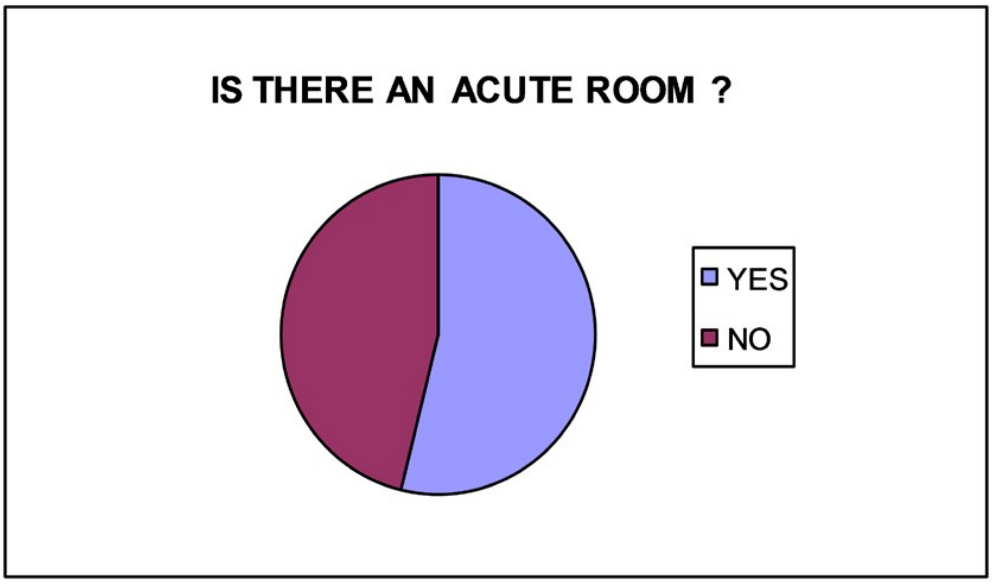
Special Wings-related Mortalities between January and July 2013. Out of the 19 admissions to Special Wings, 9 died. [Most died within 48 hours]

Table: Mortalities following CCU discharges with tracheotomies to the wards during 3 months period in a given time of the study period

Patient	Primary Diagnosis	Receiving Ward	Date of Discharge From CCU	Days to
01	Respiratory distress	R	03.06.00	12 days
02	Obstructive Hydrocephalus shunting	S	3.06.00	12 days
03	SHI/Intracerebral haematoma	T	10.06.00	5 days
04	Acute Bronchospasm	U	10.06.00	80 days
05	OPP in psychosomatic disorder	W	29.08.00	30 days

There may have been some relationship between tracheomized patients discharged to the ward from CCU and apparent poor outcomes

7. 4 Derived Facts from the Survey



Only 7 out of the 13 wards had an acute room allocated for acute & critically ill patients while 6 had no acute room

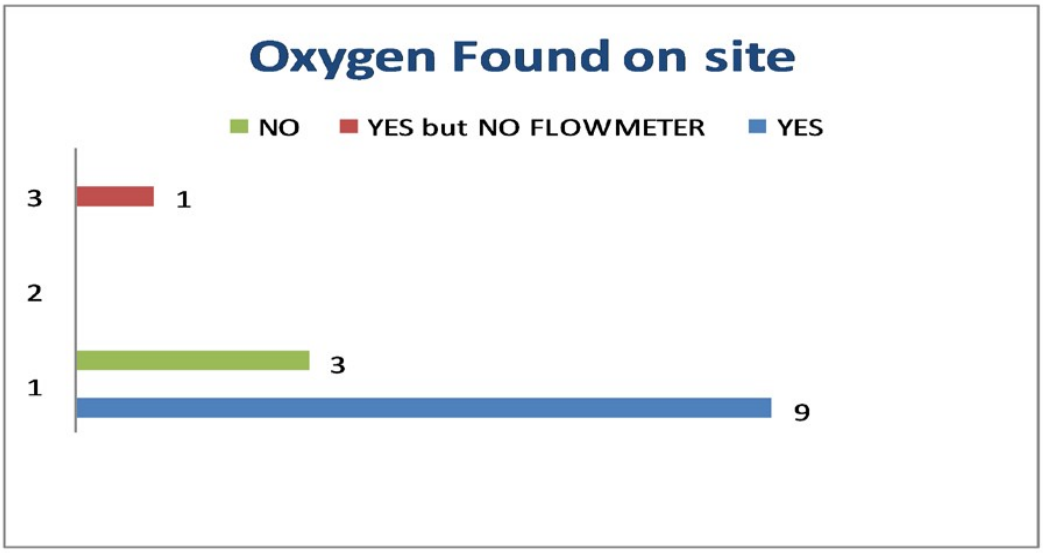
Acute & critically ill patients were mixed with others in 2 wards

Acute & critically ill patients were nursed in rooms chosen for them by relatives in 2

wards Patients managed as per Firm admitting in some wards

On average there were 8 beds in each acute room with an average of 9 patients in each acute

room. Only in two wards was at least one nurse found in the acute room.



In 5 wards there was a suction machine on site in the acute room. In 8 wards there was no suction machine on site

Table: Location of Resuscitation Tray

	n =
Nurses' station	7
Admissions area	1
In Acute Room	1

Table: Contents of Resuscitation Tray

	n =
Fairly complete	7
Grossly incomplete	6
Adrenaline inj found	10
No adrenaline inj found	3
Atropine inj found	12
No atropine inj found	1

7.5 Conclusions

Acute rooms were a commonplace in the wards except in certain cases. The acute rooms were inadequately equipped and inadequately staffed

11am-1pm was on a week day was prime time staffing-wise, high value and labour intensive. This would be expected to fall short during the buffer, night, or weekend shifts. Observations during a "snapshot" might not be representative (e.g. number of patients/acute room).

Without Oxygen that's not an Acute Room

Emergency tray needed to be stocked using the patient's file and therefore it was difficult to have stocks.

7.5.1 Recommendations

What changes the outcome in acute care and critical care settings is monitoring and timely intervention

A. Acute rooms should be adequately

equipped Oxygen

Suction

Pulse Oximetry

Fluid therapy and parenteral nutrition

Resuscitation trays that are uniformly stocked and regularly checked Adjustable beds

Side rails on beds

What changes the outcome in Critical Care settings is monitoring and timely intervention

B Adjunct staff

Adequate adjunct staff –for example, Physiotherapy services available both day and night including weekends on a 24/7 basis.

D. Acute room nursing staffing

-Should be consistent

-Should be present in acute room at all times

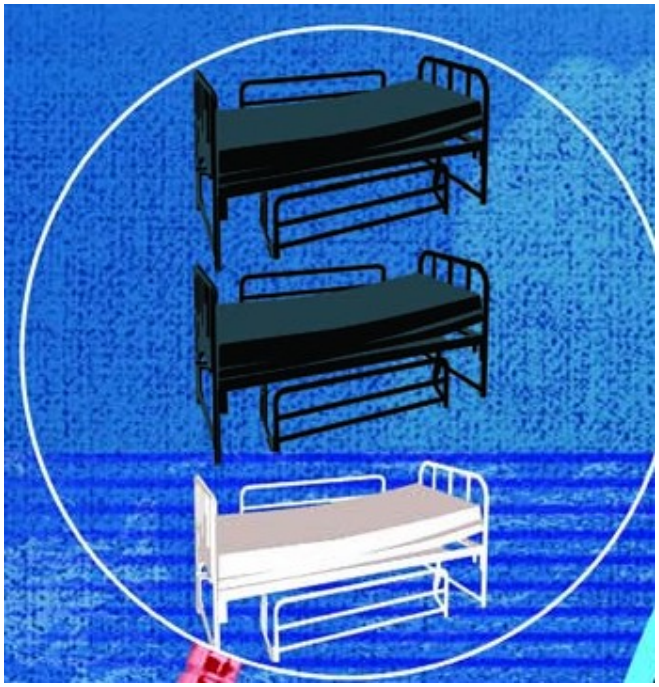
-Should be adequately trained in airway management and resuscitation skills

- It was better if the acute room could be arranged around a central Nursing station.

-That the purposely built Nursing stations in the wards revert back to their former intended noble use for nurses to increase the proximity of care givers to the patients. This may call for repossessing/reclaiming some of them from their current users (billing, social work, and records staff).

E. Patient attendants to support nurse

F. Fluid therapy, Vital signs monitoring, Nutrition



Pic: Beds with adjustable siderails were yet to become common place in the public hospitals

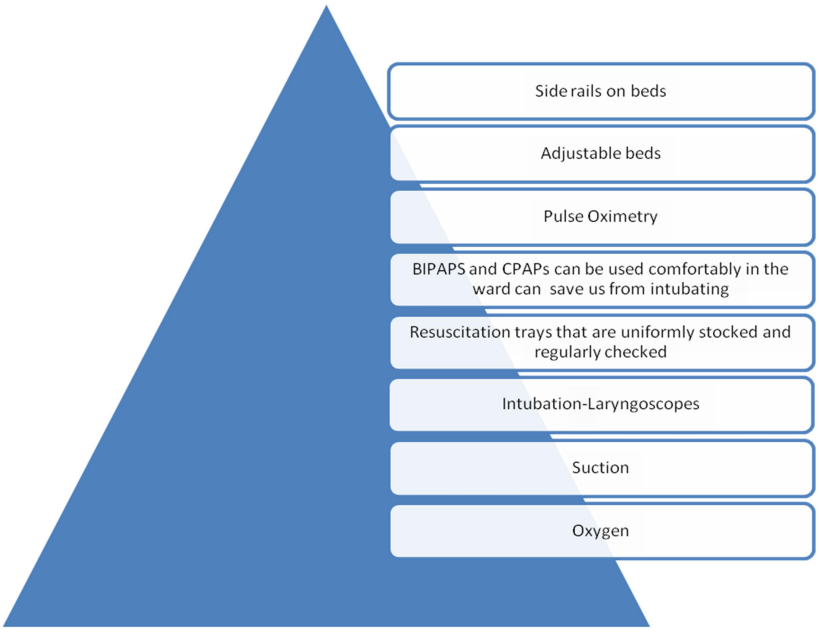


Figure: A spectrum on acute room setting recommended for developing countries

G. Role of Critical Care - Way forward

Commitment to the formation of an institutional multidisciplinary Rapid Response Teams mandated and equipped to be called upon to respond to need for resuscitation and stabilization of a patient; in other words preparation and 'Best Care Anywhere'.

Initiate Non-invasive Ventilation to patients who cannot access CCU/HDU. To be managed in an acute room in liaison with critical care staff. This will utilize BiPAP (Bi-level Positive Airway Pressure Ventilation) and CPAP (Continuous Positive Airway Pressure Ventilation. In other words continuous supply of basic crosscutting equipment and drugs.

Larger High Dependence Units for patients discharged from CCU

Increase capacity of CCU to meet needs of the hospital for acutely & critically ill

patients CCU staffs continue walk-through surveys

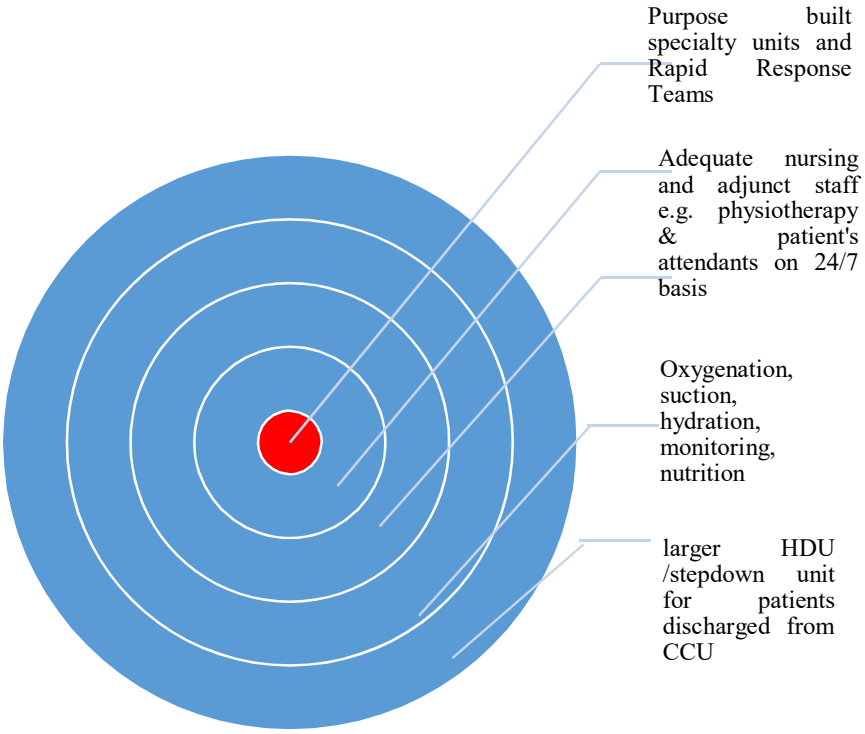
Track outcomes of patients discharged from CCU to acute care settings. 'Keeping our finger on their pulse'. Every part of the hospital must give quality care.

Chart review could have had some inference to poor patient management outcomes related to the Private Wings- maybe Private Wings should take it up in their clinical audits.

Link up of CCU with the wards

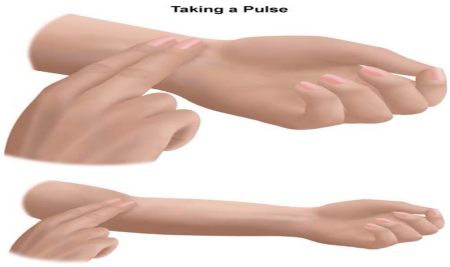
Other Centres comparisons

Figure: The darts framework: targets and span for current and future needs of a level 5 hospital



Increase capacity of CCU to meet demands of the hospital and the catchment area

Figure: CCU has a role 'keeping a finger on the pulses' on patients discharged to Step-down units and acute rooms and wards



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CHAPTER 8

Evidence-Based Practice

Overview

Improvements, accomplishment, and progress in health care (and science in general) result from carefully building up on the research findings of those who have come before us. The results that they shared, published and how that has been understood by others. The key to this is the useful feed-back they received.

Evidence-based practice (EBP) is the conscientious and judicious use of current best evidence in conjunction with clinical nursing knowledge and patient values to guide healthcare decisions. The process begins with a question, followed by an extensive review of the literature to evaluate what answers and discussion already exist. In this context then, the term evidence-based practice (EBP) is hard to avoid in contemporary health care even in resource-constrained settings.

Even if an organization were to pretend that it is not motivated to rely on interventions that have been shown to be effective a host of external powers would push them towards quality. These include statutory regulators, quality management systems (QMS), and accrediting organizations among others. They not only expect it they will be appraising them from time to time.

A US report indicatd that less than 40% of hospital care was based on research evidence supporting its efficacy (IOM Roundtable on Evidence-Based Medicine, 2007) The report lamented that, "Care that is important was often not delivered. Care that was delivered was often not important". There was also an often cited 17-year latency between bench (translatable research) and bedside (Morris *et al.,* 2011). Health systems research was especially in demand, why because many countries including developed countries faced underutilization of necessary care, the overutilization of inappropriate care, rising costs, disparities in access to care, patient safety concerns, and outdated public health infrastructures among others.

EBP, in this case, referred to as evidence-based management is the utilization of various types of research evidence by managerial leaders to support decision making to improve processes and outcomes. EBM provides managers with the resources they need to create positive change. A gap existed in healthcare leaders' understanding of how to utilize appropriate evidence to improve inefficiencies in healthcare delivery.

It is critical for healthcare professionals to understand and apply strong evidence to every aspect of healthcare. System-level research leading to innovations was needed to address what are increasingly recognized as system-level problems through what has come to be referred as learning organizations. Learning, in this case, refers to the capability for continuous improvement through the collection and analysis of data, creating new knowledge, and the application of the new knowledge to influence practice.

A learning organization should acquire the ability to continuously, routinely, and efficiently study and improve itself. It ought to create an enabling infrastructure and engage care providers and connect them in peer learning communities, develop analytic tools to interpret and manage data among others. The validated information allows care providers as well as their leaders to perform their jobs with higher standards and better outcomes.

This Chapter sets the pace for five subsequent ones dealing with evidence-based practice, which is a cornerstone of quality health care. Why is this so important? Studies have shown that two out of three clinical encounters generate a question, yet only 40 percent of those questions are answered. If they were all addressed, it could change up to eight management decisions each day

- a clinically significant impact. This is a call for evidence. For a long time, scientific research was left to academics but that can no longer work in healthcare, every health care provider is accountable for determining the value of their interventions. Why EBP? Every patient deserves care that is based on the best scientific knowledge and that ensures high-quality, cost-effective care.

However, the following was one nurse's response o why EBP: *I have an entirely different way of addressing clinical questions. I'm starting to ask questions about how I can improve the care I give to patients and how I can be involved in my workplace's efforts to improve care for the patients it serves. I have discovered by purposeful reading in my practice area that research reports and research summaries contain many implications that apply to practice in the critical care unit (Jill Webbs in Vignette).*

The first part of this chapter is an excerpt of a modified essay that was submitted to Global Research Nurses competition whose theme was- *"with reference to a research study that you have worked on, describe how nurses contribute to clinical research and discuss what support is needed to enable greater involvement for nurses in clinical research"*. The essay related to small efforts that when followed brought among others; a tracheostomy study, infection prevention practices and control (IPPC) study and a walkthrough survey, self and accidental poisoning study, applying theory into practice (Newman and Nightingale theories among others covered elsewhere in this book.

The advent of Evidence-Based Practice became one of the benchmarks to interrogating the provision of quality health care if it made a real difference. An overview is presented of one practice model, the Iowa Model of Evidence-Based Practice to Promote Quality Care since I felt that it was one of the easier models to understand. The model was initially meant as a practice model but has had varied applications by teams, units, and organizations in research, academia, grant proposals, publications, knowledge attitude & practice (KAP) studies regarding research and EBP.

Another factor that has been proven to edify the quality of health care provision accepted in EBP is embracing theory into practice. There is need to let the reader be in a position to relate with how all these might occur in practice. Slightly adapted Advanced Theory in Nursing and State of Science 1: Evidence-Based Practice coursework materials were used. Valuable updated relevant readings and links have been provided (in text and in the references section) together with a template for staff training on electronic library searching.

Traditionally, knowledge was viewed as something that can be possessed. Today, however, it is viewed as a utility-something not possessed, but access. People who want to use knowledge should know how to access it, how to apply it, and when to let it go (Porter-O'Grady & Malloch, 2015).

According to Houser and Oman (2011; p14, 47,249, 251), EBP is not a *cookbook medicine*, handing down edicts to the health care provider to practice in a single way. Infact, evidence alone is never sufficient to make a specific clinical decision about a specific patient. The clinician needs evidence plus good judgment, clinical skill, and knowledge of the patient's unique needs to apply evidence specific to the patient situation. Evidence (basing practice on what has been explored, tested, and found to serve the health needs of patients) is one of the triads in EBP.

The other two are clinical experience (expert panels, consensus statements etc. not sacred cows) and patient preference (satisfaction, patient-centred, cognizant of cultural values, quality of life, treatment burden, co-morbidities etc.). Therefore EBP is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. It is also a process of finding, appraising and applying scientific evidence to the treatment and management of health care. It involves using the best research-proven assessments and treatment in our day to day client care and service delivery. Nursing research provides the foundation for evidence-based nursing practice.

8.1 How Nurses Contributed Towards Generating and Utilizing Evidence

According to International Council of Nurses (ICN, 2012), nurses were excellent at giving care and at solving immediate problems, often with few resources. They interacted with consumers of health care in a wide variety of settings. This gave nurses a broad understanding of health needs of how factors in the environment might affect the health situation for clients and families, and of how people might respond to different strategies and services. Yet, nursing has difficulty getting this message out to policy-makers. They proposed that national nurses' associations were best positioned to influence policy by bridging the bedside to boardroom divide.

The feeling of this author is that we must start by utilizing EBP from where we are. First and foremost there is need to focus on changing competences and attitudes towards translating evidence to practice for better health outcomes.

This is what happened in a couple of years back in one level six hospital in western Kenya. The critical care nurses had noted with concern that after CCU patients with tracheotomies were transferred to the wards, many suffered poorer outcomes than expected. After conducting a retrospective chart review of all these cases to document the problem. It was alarming to find out that 78% died within 72 hours to 60 days following their transfer from Critical Care Unit (CCU).

A team of nine CCU nurses then conducted a survey of acute rooms in the hospital. Some other key findings included that there were inadequate resuscitation facilities: suction machines and oxygen were not in every ward, emergency drugs were not well stocked, and acute rooms did not always have a nurse. No protocols existed on resuscitation or tracheostomy care.

The study recommended the creation of a step down high dependence unit (HDU); placement of a nurse in every acute room; stocking each ward with a minimum of one suction machine, an oxygen administration set and pulse oximetry.

Of all the projects this unit implemented, the tracheostomy study stood out. They wanted to: (1) assess the current state of tracheostomy care in primary and tertiary healthcare facilities, and (2) assess the knowledge, attitudes, practices and skills of ward nurses in tracheostomy care. Utilizing a descriptive cross-sectional survey of knowledge, attitude, and practice of tracheostomy care among ward nurses.

Although these critical care nurses had little to no background in research, the team leader sought the commitment from all of the nurses to form a team and each began a small research study. The team leader continued to mentor them, structure how they would work through the process of proposal writing, and helped them expedite proposals through human subjects review.

With the assistance of visiting nurse researchers who lent access to US university databases, they conducted a literature review that revealed adverse outcomes were related to tracheal occlusion in patients discharged from CCU to the wards. Occlusion of tracheostomy occurred in the absence of proper nursing care which might be due to lack of education and existing protocols.

Another finding was that nurses felt tracheostomy care was the doctor's responsibility, while doctors felt it was a nursing responsibility. The study recommended that protocols for tracheostomy care and education were needed in order to inform nursing practice throughout Kenya.

Going forward, since then tracheostomy care workshops were held. The intention was to follow up with a post-training questionnaire on the same sample and analyze the comparisons. Anecdotal evidence already showed improved patient outcomes. The expanded project would include a primary level facility with the intention of comparing with the level 5 facility. These would be replicated throughout the Rift Valley Province. It was hoped that with some assistance (have since applied for a grant) it would be possible to publish these experiences and existing knowledge base in the form of a manual.

Many other small projects emerged, such as a study of 'buffer' shifts (4 to 6.30pm) that demonstrated the shifts were actually detrimental to patient care. In another study, three nurses conducted an assessment of infection prevention practices and policies which resulted in a practice change (Gichuhi, *et al.,* 2015). These nurses presented their study at several conferences nationally.

Some other CCU nurses conducted an audit of poisoning cases admitted to CCU in the preceding four years. It was assumed that all patients were suffering from one kind of poisoning and treatment protocols did not exist. After a literature review, they were able to develop an assessment tool to distinguish the type of poisoning and appropriate treatment. The rate of mortality of patients with poisoning dropped to a clinically significant level (Kamau, Chebor & Mwangi, 2014). These were but a few examples of studies conducted by CCU staff after creating positive expectations and creating an environment of collaboration and support.

In the past, nurses in that institution were rarely involved in developing concept papers, proposals, and budgets. Nurses often were recruited as data collectors after a study was underway. This was a significant step forward for nurses now that they were the instigators of searching for evidence and if there was none: observed and identified questions related to patient care, designed and carried out the study, and then used the findings to make necessary changes in patient care. The importance in this change of roles for nursing could not be underestimated because it meant that questions that had to do with the welfare of patients could be addressed directly and that nurses in other units saw the benefit and reward of this activity and followed suit.

8.2 Support needed to enable greater involvement of nurses in research

According to Chipps *et al.,* (2017) acute care hospital environments provided excellent settings for clinical nurses to conduct research that aimed at improving quality and patient safety. In the US, Magnet® recognition was one approach frequently used to develop a culture that promotes robust scientific inquiry among nurses.

In low-resource countries, such as Kenya, there are other strategies that would stimulate nurses' increased participation in research and use of research, for example waiving the reviewers' and publication fees, providing access to scholarships for graduate education, access to high-speed internet, computers and databases, to provide staff time out to do research and funding for studies. Most of these were recognized more than a decade ago by the classic works of Haynes (1998) and Rogers (1983).

Such an effort jointly by Shearwater Foundation/International Peace corps and Moi University duly recognized that this author benefited from had its own parameters. The statement announcing the scholarship read in part as follows: - *Two scholarships each approximately $4,000 USD to pursue Master's Degree studies in Nursing will be awarded in the year... The purposes of these scholarships are to:*

- *Provide future educators and mentors for practicing nurses and nursing students especially within MTRH and Moi University School of Nursing.*
- *Provide critical thinkers, researchers, advanced practice nurses, nurse managers, and political advocates for social justice in health care who can influence positive health care outcomes in Kenya*
- *Provide nurse experts for the further educational development of Kenyan nursing at the local level.*

Indeed, as health care providers we really are a part of a global community! We all have such rich experience to share. A lively participation in an online discussions forum is so enriching. As I sat at my desk in Kenya I realized we too could contribute in some way in developing innovative solutions to big global issues of our time – extreme poverty, inequality, and climate change. Why not? Some of my networks were sitting at their desks or whatever it was in Nigeria, in India, in Afghanistan, in Myanmar and in dozens of other countries. We were all discussing modules on *Leadership and Management in Health* (LMIH) course hosted by University of Washington.

Having opportunities to attend the conferences were such valuable experiences allowing nurses to hear the work of others, to network with and share experience with others from countries where nursing research had evolved or was in the process of evolving. Global Research Nurses Network offers such a forum. From time to time they do run competitions for nurses from resource-constrained settings; winners get full sponsorship to attend international a conference wherever it will be held next.

Global Research Nurses Network principally promotes clinical research. But there were other schools of thought concerning nursing research. For example, Jacqueline Fawcett Ph.D. considered a theory expert and internationally recognized as an authority in models of nursing wrote that nursing research is all about either generating a new theory or testing one which is already there. This was a masterpiece she co-authored *Contemporary Knowledge in Nursing Practice* (Fawcett and Desanto-Madeya, 2012) that connects research and theory. She was honored with Betty Neuman Award during the *Nurses Research Day* on 18th October 2015 for her distinguished role in promoting nursing research.

As we consider stepping up the quality of healthcare provision, whether we are at Research Utilization or Evidence Based Practice there will be tools available to choose from. An example is Iowa Model of Evidence-Based Practice that recognizes triggers in practice as the catalysts that prompt the need to seek knowledge.

The University of Iowa Hospitals and Clinics' (UIHC) Department of Nursing was known for its work on the use of research to improve patient care. This reputation was attributable to staff members who continued to question "how can we improve practice?" or "what does the latest evidence tell us about this patient problem?" and to administrators who support, value, and reward EBP.

According to Basow (2013), studies have found that two out of three clinical encounters generate

a question, yet only 40 percent of those questions are answered. If they were all addressed, it could change up to eight management decisions each day - a clinically significant impact. Fineout-Overholt and colleagues (2005) described four components to forming an appropriate clinical practice question "PICOT". One of the most challenging issues in using EBP in the clinical setting is learning how to adequately frame a clinical question so that an appropriate literature review can be performed utilizing a "**PICOT**" model acronym:

The PICOT question format is a consistent "formula" for developing answerable, researchable questions (Melnyk & Fineout-Overholt 2011). When you write a good one, it makes the rest of the process of finding and evaluating evidence much more straightforward.

P: Population/patient - age, gender, ethnicity, individuals with a certain disorder

I: Intervention/indicator (Variable of Interest) - exposure to a disease, risk behavior, prognostic factor

C: Comparison/control - could be a placebo or "business as usual" as in no disease, absence of risk factor, Prognostic factor B

O: Outcome - risk of disease, accuracy of a diagnosis, rate of occurrence of adverse outcome

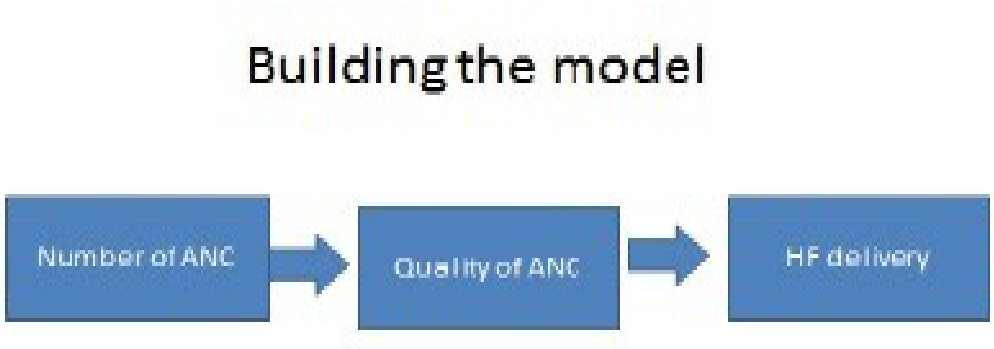
T: Time - the time it takes for the intervention to achieve an outcome or how long participants are observed

Note: Not every question will have an intervention (as in a meaning question) or time (when it is implied in another part of the question) component.

Additional letters (PICOT**TS**)
T: Type of study
S: Setting
More resources https://guides.nyu.edu/c.php?g=276561&p=1847897

The nurse practitioner needs to consider each of these components when developing a focused question. Once the PICOT question has been formed, a literature search is performed. Successful search and critique of the literature is a critical component for nurses to master when implementing change driven by EBP. According to Fineout-Overholt *et al.,* (2005), correct literature appraisal assists how the evidence will be used to answer the PICOT question or implement a practice change.

We might have observed from day to day work that a relationship is found between the number of antenatal care visits and delivering at a health facility. That is, if the quality of ANC is good (quality means that mother receives all services such as iron supplements, BP, urine tests, education on health facility delivery etc.), they are able to understand the importance of HF delivery.



Begin by defining the variables:

Dependent Variable: - Delivering at the health facility (HF);

Independent Variable: - No. of ANC visits;

Moderating variable: - Quality of ANC.

"PICOTTS" model

Population women visiting ANC (who also delivered at HF, or visited ANC but did not deliver at HF). It excludes all those who either did not visit ANC but delivered at HF or those whom we do not have proper records to ascertain this status.
Intervention -ANC care

Comparison - No of visits (few less than 4) and more (at least 4 or more), or late 1st attendance of ANC versus early/regular attendance. Could also be the quality of ANC but this would have its ethical implications since no justification whatsoever that a woman can be deliberately denied quality care. But circumstances might arise when supplies were lacking this period can be compared with another one where there was plenty.
Outcome is health facility (HF) delivery
Time – when ANC care, schedules etc. **T**- type of study, **S**- setting

If we do not know something, we can research on it - that was why we went to school. Literature searching techniques are beyond the scope of this book and the reader is directed to further reading in the references below, a rubric utilizing medical heading (MH) or Medical Subheading [MeSH] on HINARI PubMed and CINAHL databases has been highlighted in the Research Brief and Annotated Bibliography (see Chapter 9, Table 6). HINARI PubMed is available free to all developing countries. Individuals and Institutions can subscribe. Electronic library searching is an indispensable skill to muster in today's world.

Though you could do that, do not (impulsively) search Google or Yahoo for your literature, there is a better way. Endeavour to do things differently, save time and reduce unnecessary hits. Start a notch higher this time. Time for change is upon us. Due to the importance of this activity, a proposal to train staff on electronic library skills a template for you to adopt is available as an addendum below. Ask your Librarian for assistance, a System/Research Librarian near you would be willing to give you some tuition on the electronic literature search.

If you have access to more institutional databases I would recommend going straight to systematic reviews which save you the trouble of doing the summaries yourself. A credible literature search will have been done for you by dedicated staff. In terms of the hierarchy at the bottom of evidence-based practice are opinions from experts, and yet these have been what many have relied on for decades during ward rounds and such like forums. Of course, there continue to be clinical practice questions for which there is relatively little research information and experts can be helpful here (Level VII) see table below.

According to Porter-O'Grady, T. & Malloch, K. (2015) in their masterpiece: *Quantum Leadership: Building Better Partnerships for Sustainable Health* "It is nearly impossible for a single person to know more than 10% of what there is to know about a particular topic." It's a great reminder that we can't possibly "know it all", "Lone geniuses are out. Collaboration is in," and that we can all learn from one another/co-laboratories (emails, video conferencing, shared whiteboards, databases) This way we will not only learn other ways on *how to do* but also concerning what we do, *how to do better*. (Also see Table below).

Nevertheless, many nurses do not know how to access research evidence, do not possess the skills to critically evaluate research findings and even those who do may not know how to effectively incorporate research evidence into clinical decision making. We need to move from Level VII and that is the way to go. But the searching skill even for these constrained databases will still be necessary for you.

EBP is considered a major shift in health care education and practice. In the EBP environment, a skilful health care provider can no longer rely on a repository of memorized information, but rather must be adept in accessing, evaluating, and using new evidence that emerges in systematic research (Polit & Beck, 2012). The Agency for Healthcare Research and Quality (AHRQ) produced a "knowledge transfer framework," This is a recommended resource for those who would like to further their interests in these areas.

Table: Evidence hierarchy: levels of evidence regarding the effectiveness of an Intervention

Level I: Systematic review of Random Controlled Trials (RCTs) or Systematic review of RCTs
Level II: Single RCT or Single non-randomized trial
Level III: Systematic review of correlational/observational studies
Level IV: Single correlational or observational study
Level V: Systematic review of descriptive or qualitative or physiologic studies
Level VI: Single descriptive or qualitative or physiologic study
Level VII: Opinions of authorities, expert committees

When it came to expert opinion (see **table on evidence hierarchy** above) it was important to appreciate what we have. A case in point was that of Mr Francis Amakoye, an Occupational Therapist with over 35 years' experience based at Alupe Kenya Medical Research Institute (KEMRI). He had distinguished himself an expert at diagnosing and treatment of leprosy. The institute hosted the only leprosy centre in the country. Leprosy and especially in children was a challenging area among the emerging and re-emerging diseases which was hardly taught in conventional medical schools even in tropical Africa. He received hundreds of students every year who look forward to picking his brains, and he never disappointed.

May be as a result he made this comments during one such educational visit 'don't Google anything as long as I am still alive, Google my head'. [This author had been part of such at delegation 4 times in 15 years].

8.3 Demystifying Research

The research tradition includes six rules that encompass all phases of an investigation following some rules:

1. The first rule identifies the precise nature of the problem to be studied, the purposes to be fulfilled by the investigation "a way of seeing one's subject matter on a concrete (making real) level, thereby allowing puzzle solving to take place". There will always be empirical work (usually meaning experimental) needed to generate and test theories, conceptual 'models, frameworks', fill gaps in other research or come up with something new or angle. There was an evolution of concept analysis methods in nursing, redefining concept - based research methods. The frameworks proposed in this book (Chapter 6) inform a developing concept about interrogating health systems in resource-constrained environments.

2. The second rule identifies the phenomena that are to be studied. Meaningful research ought to provide answers to the most pressing problems encountered, it rends itself making a significant contribution to the body of knowledge/discipline; or could quite possibly be the major accomplishment of the decade. Imagine if one was to do a research that identifies why there is a trend of an emerging jiggers menace in Kenya.

Refinement of key words for library search by serving as a focus-"ruling some things in as relevant, and ruling others out due to their lesser importance", literature review

3. The third rule identifies the research techniques that are to be employed and the research tools that are to be used.

4. The fourth rule identifies the settings in which data are to be gathered and the subjects who are to provide the data.

5. The fifth rule identifies the methods to be employed in reducing and analyzing the

data.

6. The sixth rule identifies the nature of contributions that the research will make to the advancement of knowledge and recommend what more work is needed to identify other puzzles and to develop methods for their solutions. Dissemination of findings is critical.

Numerous evidence-based models are available to assist practitioners in using evidence in their practice According to Titler, (2007), they all share certain steps:
Select a topic (for example, diabetes self-care management).

1. Find and critique the evidence. Notice where there are significant differences of opinion among researchers and give your opinion based on what you see as the differences, ascertain the areas in which little or nothing is known, the gaps that exist in the body of knowledge
2. Adapt the evidence for use in a specific practice environment.
3. Implement the BP.
4. Evaluate the effect on patient care processes and outcomes.

The Iowa Model of Evidence-Based Practice to Promote Quality Care (discussed below) to clarify the steps needed to put research into practice, with the goal of improving the quality of care.

8.4 The Iowa Model of Evidence –Based Practice

8.4.1 Model Overview

The Iowa model highlights the importance of considering the entire healthcare system from the provider to the patient, to the infrastructure, using research within these contexts to guide practice decisions. A number of steps have been identified in the Iowa model to facilitate practitioner's engagement in problem identification and solution development as it relates to incorporating evidence findings into practice.

The first step in the Iowa Model of EBP is to identify either a problem-focused trigger or a knowledge-focused trigger that will initiate the need for change. A problem-focused trigger could be a clinical problem, or a risk management issue; knowledge triggers might be new research findings or a new practice guideline (See Appendix XVIII).

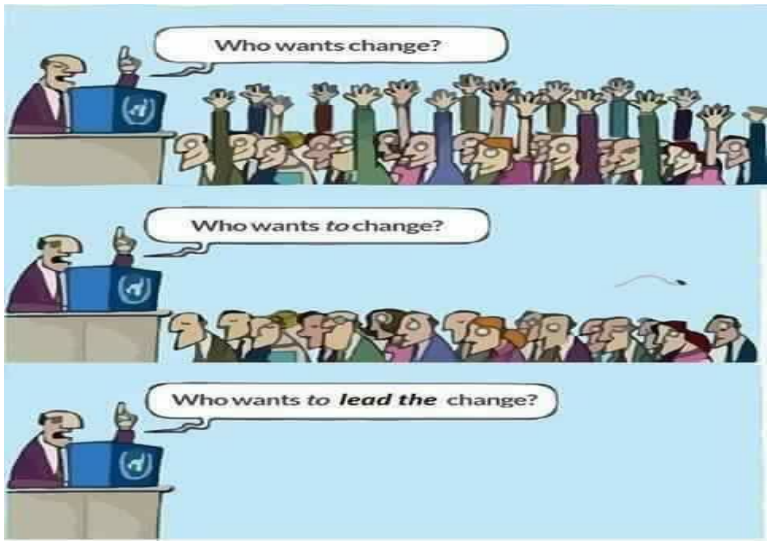
The first version of Iowa model (often called the 1994 version) was developed at the University of Iowa Hospitals and Clinics (UIHC), mainly to guide what was then referred to as research utilization (Titler, et al., 1994). The model has been in place for over 20 years at UIHC, during which time it was revised and updated in line with quality improvement and EBP literature (Titler et al., 2001).

The Iowa model is a practice model with the primary purpose of guiding practitioners (including physicians, nurses, allied health) in the use of evidence to improve outcomes (Rycroft –Malone & Bucknall, 2010; p138, figure 6.1). It is based on planned action process and incorporates conduct of research, use of research evidence, and other types of evidence e.g. expert opinion and consultancies.

Knowledge-focused and problem-focused "trigger(s)" lead staff members to question current health care practices and whether patient care can be improved through the use of research findings. Priority should be given to topic/project which is a high priority for the organization. A team is formed that assembles relevant research and related literature, critiques & synthesizes research for use in practice. If it is found that there is not a sufficient number of scientifically sound studies to use as a base for practice, consideration is given to conducting a study. Other types of evidence e.g. case reports, expert opinion may also be incorporated where need be.

If a practice change is warranted, changes are implemented using the process of planned change, piloting the change with small groups of patients and evaluating it and refining it to see if the change is appropriate for adoption in practice to additional population(s). 8.4.2 Assumptions:

(a) Working as a group/team is an important part of applying evidence in practice;
(b) Evaluation is essential part of the process of EBP;
(c) EBP is a process, not an event that requires multiple steps to align clinician behaviour and system support for delivery of evidence-based health care;
(d) The model is applicable for various health care disciplines, not just nurses and that improvement in processes and outcomes of health care are often interdisciplinary in nature.



Pic: Dynamics of change (courtesy of the clip developer)

8.4.3 Intended Users and Utility

Intended users for the Iowa model are practitioners. The give and take of ideas as the basis of developing a good project. Although originally designed for practice the model has been adopted by some academic settings and used to integrate EBP content into curricula.

Since the original publication in 1994, the authors have received over 1200 requests (including this one) to use the Iowa model for publications, presentations, grant proposals, graduate and undergraduate courses, clinical research and EBP programs. It has been cited over 90 times in nursing journals articles. Multiple publications from staff at the University of Iowa illustrate the application of the model and include evaluative data regarding the impact of changes in practice.

The Iowa model was also used as the framework for the Advanced Practice Institute: Promoting Adoption of evidence Based Practice 3-day train–of trainer program (TOT) at UIHC under the author Marita Titler (Rycroft –Malone & Bucknall, 2010). It has also been used to guide EBP Internship program. Evaluation data and details from these programs are used to improve on the model.

8.4.4 Theoretical underpinnings

Theoretical underpinnings of the Iowa model come from quality and performance improvement and organization systems literature. For example, the decision point regarding "is this topic a priority for the organization?" illustrates the importance of organizational support for implementing EBP. The evaluation component, dissemination of evaluative findings, and the feedback loops illustrate theoretical underpinnings of quality and performance improvement in the model. The model differentiates between the conduct of research and the process of EBP.

8.4.5 Hypothesis generation

Although the Iowa Model is a practice model rather than a research model, it has generated research hypothesis and been used in 19 grant proposals. It has also been used to guide assessment of knowledge, skills, and attitudes regarding research and EBP with subsequent educational programming for staff to improve the use of evidence in practice

(Witzke et al., 2008).The model has been tested and evaluated in acute care settings through numerous EBP projects on various topics: the return of bowel sounds following abdominal surgery in adults, preventing aspiration with enteral feedings in adult critically ill patients (Bowman et al., 2005) among others.

8.4.7

Strengths

- It starts with a small pilot of the evidence, is the evidence and changes important to the organization? (Priority is given to topic/project which is a high priority for the organization – does it fit the context and its' vision, mission, and goals?). It guides the user through implementation and evaluation of implementing changes.

- An excerpt from the Catriona M. Doody and Owen Doody (*n.d*) article entitled Introducing evidence into nursing practice: using the Iowa model states, "To develop an evidence-based practice at the unit level, the team should draw up written policies, procedures, and guidelines that are evidence-based. Interaction should take place between the organization's direct care providers and management such as nurse managers, to support these changes".

- The team work is emphasized. The Doody's article highlighted the importance of team composition and a bottom-up approach to implementing evidence-based practice. This is essential as change is more successful when initiated by frontline practitioners, rather than imposed by management.

- It is intuitive for practitioners and decision points in the model assist in driving the process forward. The model seems more user-friendly so practitioners without experience in this field can use it more easily step by step.

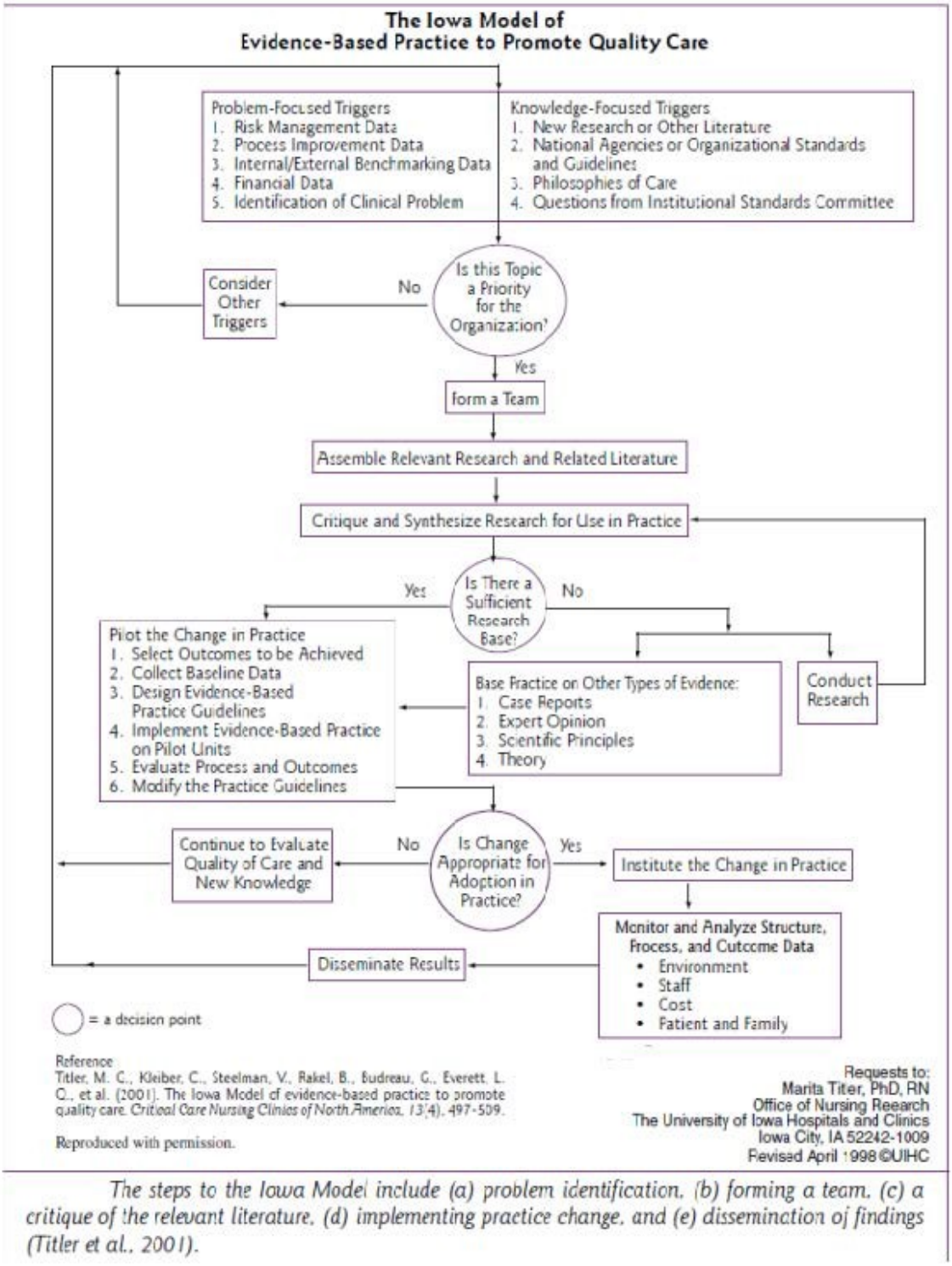
- It is multidisciplinary and multi-institutional.

8.4.8 Weakness

A major limitation of the Iowa model was on using teams of clinicians to address EBP issues, rather than individual practitioners. Patient's preferences apparently were missing or rather visual reminders in the model graphic would have been very valuable. It puts patient and family so far towards the end of the process. Its focus was much more from the view of the organization and steps of preparation. It might have been better if it had the patient at the centre, kind of orients everyone to why we are doing what we are doing.

Although the model had been tested and evaluated in acute care settings e.g. through numerous EBP projects, it had not been revised since 2001 (Geissler & Kirst, 2009). A consortium of Iowa University Hospital and College of Nursing employees was working to revise the model but was yet to release their results by the date of publishing this book.

Seven steps of the Iowa Model (below), modified from Doody & Doody (n.d) 1*: Selection of topic 2:Forming a team 3:Evidence retrieval 4: grading the eviene 5:Developing an EBP standard 6:Implement the EBP 7:evaluation*



The steps to the Iowa Model include (a) problem identification, (b) forming a team, (c) a critique of the relevant literature, (d) implementing practice change, and (e) dissemination of findings (Titler et al., 2001).

(Also See Appendix XVIII)

8.4.9 Discussion

It's been well documented that patients who receive research-based nursing care have better outcomes compared to those receiving "routine care" or care based on tradition (Melnyk et al., 2004).When the argument is improved patient outcomes, it is difficult to ignore. Bringing the evidence to the table gives your argument strength.

This was certainly something health care providers in Kenya can endeavour to do. One of the advantages to EBP and the use of a model such as the Iowa Model is that you gather the evidence and support to convince others why the change is necessary and appropriate for the organization.

There is this saying that the reader might have heard… "Show me the evidence"? Or "Let the evidence speak for itself'. Some people do not want to change but will if you show them the evidence. The Iowa model supports the need to gather the evidence and show it to the group you are working with to get support for the change in practice.

8.5 A Synopsis of application of the Iowa Model of Behaviour Change

(Adapted from essay turf.com) http://essayturf.com/blog/application-of-the-iowa-model-of-behavior-change/))

The purpose of this synopsis is to review the application of the *Iowa model of behavior change* to the implementation plan, discussing ways to reduce falls in the elderly with cognitive impairment in the long term facilities. Falls among elderly people might be viewed as a normal consequence of the aging process. The frequency of falls varies depending on the clinical setting. In US fall incidences in acute care range from 2.3 to 7 falls in every 1000 patient days.

However, the highest incidence of fall occurs in long-term-care institutions, like nursing homes, about 50-73% of about 1.62million of nursing home patients experience a fall each year. Falls contribute a considerable percentage of unintentional injury in elderly; can be related somehow to a considerable number of deaths. Therefore, it is important to find a way to reduce these falls (Gosney & Harper, 2012).

The Iowa model of Evidence encourages nurses to identify a problem and identify questions triggered by practice questions. This model helps nurses promote quality healthcare by making decisions that are central to patient care outcomes. This model thus is quite useful for nurses to find ways of reducing fall in elderly people. Once a facility views the elderly health as a priority in the organization it will form a team focused on developing, implementing and evaluating the practical change.

The team, in this case, would ideally consist staff nurses who came up with the practice question, advanced practice nurses and unit managers. Due to the fact that this evidence-based model enables nurses to use research evidence for better patient management outcomes and therapeutic nurse-patient interactions. This would assist in providing the best care possible to these patients. This was because; in the practice setting there was a challenge for nurses to provide their patients with the high-quality measurable care. Nurses, therefore, needed to be aware of the introduction,

development, and evaluation of evidence-based practice. The Iowa model is a good starting point for this. The Iowa model consists of seven steps.

Step 1: Selection of a topic

Here, the magnitude of a problem and its priority has to be considered, and how it applies to every area of practice. In addition, how will healthcare improve with knowledge of this problem? Other factors to consider are the availability of evidence and data in solving the problem and how much the staff is committed to solving it. In the case of fall reduction, nurses have to understand that the falls are unexpected and occur without the patient's expectation.

The factors that increase the risk of fall include the use of high-risk medications, intrinsic risks of vision, balance impairment or cognitive impairments. In addition, falls can be caused by extrinsic factors such as wearing of inappropriate footwear, poor lighting, and slippery and uneven places. Causes of fall include arrhythmia, focal muscular weakness, hypoglycaemia, medication, orthostatic hypotension, and syncope.

Step 2:Forming a team

In this stage, a team that is responsible for developing, implementing and evaluating the plan. The team should include all interested shareholders such as staff nurses and unit managers in this case. Specialist personnel in the fall will be useful at this stage to provide input and support and give their views on the viability of a certain plan for counteracting the identified problem. Evidence-based approach is best when initiated by the staff nurses themselves rather than the management. Senior nurses should help junior nurses to effect the desired change. The team draws policies, guidelines, and procedures that are written and evidence based.

Step 3: Evidence retrieval

Here, a brainstorming session is held to identify the resources that are available, and key terms that guide the evidence search. In the case of fall, the evidence can be sought from electronic databases such as PubMed, Medline, and Web of Science. Other sources include consultations with Quality Improvement and Innovation Partnership to provide guidelines for care standards that are relevant to caring for fall patients.

Step 4: Grading the evidence

In determining the evidence related falls, the selected team will need to classify collected research as either quantitative or qualitative. Qualitative data will help in the understanding of the problem whereby the focus is on describing and understanding of the problem. The theoretical development ought to be based on real experiences as experienced by the participants involved such as staff nurses and the fall patients.

Step5: Developing an evidence-based practice (EBP) standard

The team needs to set recommendations for practice based on the consistency of replicated studies. The chosen practice should centre on the patient. In the case of fall, the practice should ensure that the risk of fall is reduced in these patients.

Step 6: Implementing EBP

The hospital management and the direct care providers such as nurses should directly interact to support the changes in the evidence-based plan.

Step 7: Evaluation

This stage is important because it reviews the contribution and value of evidence to the reduction of falls. There is a need for comparison of data prior to the evidence (as a baseline) to the data after using the evidence (outcome). This will show the contribution of evidence to patient care.

Some organizations in Kenya have in place Quality Management Systems [ISO 9001:2008 ISO 9001:2015 etc.] or are aspiring towards this. It is a requirement then that they must have a vision, mission, mission statement, core objectives, goals, service charters etc. There will be projects commissioned by the top management, regulatory bodies, institutional standards, internal/external benchmarking data, grant proposals, quality improvement initiatives sanctioned from the top.

Some of the flagship projects in Vision 2030 involve building a body of knowledge in research to enhance industrialization. Performance contracting indicators have some considerable weights on ongoing and completed research projects. A few organizations in Kenya put aside funds for research; the bottleneck comes to access them due to the high level of expectation in terms of proposal writing. Some of these unutilized funds are returned to the treasury at the end of the financial year, while individual researchers continue to conduct research using their own funds.

There will be those who wish to 'go it alone, after all!!' In a rejoinder to this, my Professor, Colleen Goode of the University of Colorado Denver gave us this advice, "*It is unusual to do an EBP project by yourself. I have never done one by myself. If you are trying to change practice in an organization it takes a village"*. Dr. Goode who was one of my course instructors at CU Denver is one of the architects of the Iowa Model, a great legacy.

At one point the multidisciplinary is strength and then it is mentioned as a limitation by the authors. May be if they all have different agendas or cannot all be researchers then this becomes a roadblock to further steps in the flow diagram of the Iowa model as they would have to be trained on research.

On the other hand, Rycroft & Bucknall (2010, p.143) referred to, "the need for at least one individual or governance group (e.g., the Research Committee) to have primary responsibility for guiding users through the EBP process." You need a mentor who knows the process and steps of the Iowa model, who is knowledgeable in the area of implementation and EBP (See Appendix XVIII).

Change champions will come in handy at some point, they have positive working relationships with other health professionals, encourage peers to adopt the innovation, arrange demonstrations, and orient staff to the innovation (Rogers, 1983). Rogers wrote the masterpiece Diffusion of Innovation. From more than 4,000 studies on innovation adoption, Rogers developed the diffusion of innovation framework.

This framework was used as the basis for developing and testing a translation research model in which diffusion of an innovation (such as an EBP) is influenced by the characteristics of the innovation and the manner in which it's communicated to users (such as nurses or interdisciplinary teams) in a social system (such as a health care organization).

Just like the Iowa model it emphasized on intended users across disciplines and a team approach apart from the need for organizational support. This model approaches EBP from a systems or organization perspective rather than from the perspective of an individual provider. Bringing people to read the same page might be a challenge (Eastbrooks *et al.,* 2006). We shall explore this in a bit through groupthink in a short while in this chapter.

8.6 Why choose Iowa model over other models

By and large, this is what I would say is unique about Iowa model of evidence, and why as a leader I would choose it over other models:

1) Its intuitive design, very logical flow, easily understood by nurses with varying degrees of experience.2) It includes knowledge and problem "triggers" that prompt user to evaluate current clinical and administrative practices.
3) Promotes nursing research when evidence is lacking.
4) It has wide application

EBP needs to be taught to all hospital employees and in the nursing syllabus in order to gain institutional buy-in and compliance to its concepts and methods of application within the practice environment. There is continuing debates about how to allocate scarce resources to EBP and research among competing needs generate lots of heat but all-too-little light.

In a nutshell, the Iowa model of evidence does sensitize us to be triggered in practice and to act as catalysts for knowledge seeking. It relies on the health care provider to pull research into practice when a trigger is encountered and traditional knowledge cannot be used to solve a problem. Although the Iowa model does not explicitly allude to this, another factor that has been proved to edify the quality of health care is embracing theory into practice as seen below.

8.7.0 *GroupThink*

Janis Irving developed an influential theory of group decision making designed to explain and predict how bad decisions are made by groups. Sometimes groupthink has come out as one dysfunctional group decision making. Multidisciplinary teams for the sake of it can be defeating. In the name of being representatives from minority departments (luckily nursing is not one) an officer moves from one meeting to another all in one week in the name of inclusion - to make teams appear representative, or with a more parochial view for goodies such as sitting allowance, lunches, per diems etc. What might be going through the mind of such an officer as they engage in this ‘shuttle diplomacy'?

I guess the least of concern would be seriousness about whatever the business is all about and end up as a ‘rubber stamp'. The rigorous nature of the kind of burden in the committees' terms of reference is not for such. Take for example aspects evidence-based practice (EBP) e.g. searching for evidence, critiquing it, knowledge translation etc.

Along with not fully analyzing the problem another disservice with groupthink is the inability to think beyond what is being decided. The groupthink mentality might also come to play when groups go along to get along. It's ‘easier to get along to get along' but regardless of whichever opinion one might have there will be those who will not like it. The end result of the decision-making process is likely to be less effective than if group members questioned the information at hand, being careful to look at the problem from a variety of perspectives.

Albert Einstein (1875-1955), the world renowned mathematician said this, ‘if I had one hour to save the world, I would spend 55 minutes analyzing the problem and 5 minutes finding the solution’. Bruce Lee, the legendary karate kick-boxer also said, ‘I am not afraid of a man who practices 1000 kicks but rather one who practices one kick 1000 times’.

The group in a dysfunctional decision-making process at times make unanimous decisions that may not have fully analyzed the problem (Janis, 1982). Few people are willing to rock the boat yet this might necessary in order to arrive at the better option or best possible decisions. Self-censorship by keeping the mouth shut when experiencing doubts. Individual health care

providers who are group members might suppress critical thinking, feeling that a consensus has been reached when it has, not wanting to be the odd one out. Silence is interpreted as consent. People also find it difficult to make decisions that would proof their previous decisions were wrong.

There is a tendency of making decisions that justify the previous decision. The tendency of some decision makers to escalate commitment to a previously selected course of action when objective evidence suggests that staying the course is unwise, an individual chooses to invest further in spite of this.

Calling in others is a way of actively seeking information that confirms the validity of their decisions and they would prefer no dissenting voice of reason pointed out the irrationality or evidence to the contrary. Anyone known to have a consistent presence of mind to scrutinize facts is rarely admitted to such forums. If at all, the absence of significant criticism by *frienemies* rather than enthusiastic support of the sycophants is usually taken to mean that a proposal had astounding support.

There a gender component to this, customarily many an African woman will not speak during meetings (though this is changing) but will discuss all that happened after the meeting. In the constitution, the rule says no more than 2/3 of any gender should sit in a meeting in a public office, again affirmative action should not only require their representation but their contribution when and where it matters most, one of which is access to quality health care Their concern is not just in maternal and child health but are equal partners with men in every other aspect of health.

These might be realities our Kenyan health care managers will need to come to terms with. A number of them are sort of insulated from the issues on the ground. An old colleague used to call this *mkubwa kusimamia kazi mpka kazi inasimama*, a Kiswahili paraphrased akin to a controlling management style that leads to workers becoming less and less productive with an ultimate likelihood for a standstill.

One notorious executive who dragged on and on had a habit of introducing each line with – ‘And again… That again… But then…But again… In as much as…' Statements full of excuses discussed enablers of the problem but less on solutions. Other times one wondered whether the words had been spoken in a different language before being translated into the bad English that itself needed to be translated. Did not even pause to ask for inputs. It was hard sitting long enough through the session.

Many such a leaders have a personal stake in the matter at hand and so the outcome was already clear on forehand. Some CEOs state a preference up front and so many such meeting were never meant for decision making. Participants are left wondering why they were called in the first place.

Some shrewd leaders will have ordered for a buffet meal and drinks (even music) which take up much of the time, the rest of the time is taken up by the leader's speech, the clarion call is that ‘this meeting has been called to discuss and come up with a way forward'. Very valid points that health care providers had sequester because there was no forum to air them. Participants need to know how they were involved, how they participated, their comments- what it is they said, see how their input got incorporated.

The opposite is preferable. This is whereby there were those who might be referred to as entrepreneurs, according to Kingdon (1995), “lie in wait in and around *the boss* with their solutions [already] in hand, waiting for problems to float by to which they can attach their solutions, waiting for a development in the *organization’s* stream *of thought* they can use to their

advantage" (emphasis in italics mine). This Kingdon strategy works well in policy development process but can be otherwise misused as seen in *GroupThink.*

Too much homogeneity was a likely cause of groupthink. Group members who have are very similar background, exposures, values or beliefs are less likely to challenge the leader or each other's ideas. They tended to be engrossed in an 'echo-chamber' mentality- speaking to themselves about themselves and, rarely ventilating for those outside looking in felt. Many people mistake uniformity for unity; sameness for oneness, but differences should be seen as strengths, not weaknesses. There was need to interact together genuinely, being open to each other's influence, begin to gain new insight exponentially because of differences.

Patronage and sycophancy have an (a usurping) role in many health care meeting setups in Kenya. Issues with far reaching implications (on many things including health) are often pushed through at such opportune moments or hour as a plotted absence of perceived opponents when there is too much pressure on the members to make a decision (Dainton and Zelley, 2015).

Whereas democratic principles state that 'the minority have their say but the majority have their way', it has not always been possible to achieve even that skewed objective in many instances. If the 'tyranny of numbers' is anything to go by this is squarely where it matters, whereby members try to justify a decision by talking themselves into it, coming up with a litany of reasons why a decision is good and why anyone opposed to it is bad. Or else too much pressure (including but not limited to buying them) is put on dissenting members to change their stand. As a resulting trust is put at stake.

Inattention to results is a serious sign of a dysfunctional team due to the absence of trust among its members. This was described by Patrick Lencioni in his book called *The Five Dysfunctions of a Team.* Distrust makes it very difficult to build a strong foundation for a functioning team.

In this type of team, people are guarded; people do not respond to questions or share opinions freely and they speak carefully. When team members are truly comfortable with one another- and when they respect each other and what the other members bring to the team- they can focus their energy completely on the job at hand without worrying about the need to protect themselves.

How often we allow a member of our team to go without being an active participant as long as they are on our side. Do such workers strengthen us or weaken us? You are only as strong as your weakest link, not to mention the negative effect it would have on the other members of the team.

How often have decisions been passed within the shortest time (minutes even) and after this we spend days or months on end discussing them? Should we discuss them before we pass them or discuss them after we pass them? Which is which?

How often are meeting after meetings held to plan or discuss how the job got done than actually getting it done? Getting engrossed with what was done other than talking of best practices or most effective practices. This pre-occupation with past achievements was characterized by rambling, over-explaining or just plain boring stuff that does not add value. When looking for comments on a job done, most profitable would be opinions and views of the other people who see how it has been done, not the original person who did the job. He ought to allow people to mingle and discuss. He could choose to respond to a few of the comments thoughtfully and only when valuable.

The same reason perhaps why Fred Allen said a meeting … *is a group of important people who singly can do nothing, but together decide that nothing can be done*. This might be what happened at some point during the constitution making process pertaining to several issues e.g.

devolution of health care services.The Bomas Draft had a provision for a Constitutional Health Services Commission (Section 251 of the Draft). The Health Services Commission was unlikely to survive a political onslaught. Sort of 'majoring on minor things' as some people commented then, the medical fraternity including Kenya Medical Association (KMA) took to agitation for the legalization of abortion at the expense of among others: the Health Service Commission and merging of all laws on health into one chapter. Instead, the public saw us in bad light, sort of outlandish with some of the matters we were fronting. We forgot to assert further for the retention of the Health Services Commission in the draft. Opportunity lost!

The mutilated Bomas draft many Kenyans today wish was passed died with the aspirations of health care professionals. What followed was more debate from the health care providers after passing Constitution 2010 than before. This stillbirth has had more collective impact on the quality of health care provision in Kenya than any other issue before.

Although processes must never overtake the significance of desired outcomes (Porter O'Grady & Malloch, 2015), one way of overcoming groupthink is to develop and follow an organization-wide decision making policy (Dainton & Zelly, 2015). Adaptive Structuration Theory provides an example of such a process - Decision Making 'Complex Cyclic Path': when groups cycle through the same actions every time to solve a problem.

This path will provide a structured, expected and consistent path to follow to think through and understand presented problems and the solutions arrived at. Organizational culture must encourage questioning, especially of decision-makers' assumptions & propositions. Seven decision making steps along the cyclic path were shared by a school health nurse (see seven decision making steps along the cyclic path below).

One last point about meetings and emotional intelligence: Even when you do not get your way remember at the back of your mind -There will always be another meeting. Learn when to slow down. Don't win the race at the expense of your colleagues, friends and family.

8.7.1 Seven effective decision making steps along the cyclic path

1. Background to problem: Need to clarify our sick policy so that parents understand when to keep children home, and staffs understand the criteria to follow to properly educate parents and provide consistent care to caregivers

2. Problem Presented: Too many children are coming to school sick, inconsistent standards amongst staff

3. Solution: Create a clear, simple language illness policy that includes a parent handout, send handout out frequently during high illness times

4. Resources: Support through hospital epidemiology department and school health program, possibly adapting their illness policy

5. Timeline: Rolled out within 3 weeks

6. Who is Responsible for Success: Infection Control Nurse, Charge Nurses and Managers

7. How follow through will be conducted: Manager will follow through with compliance audits

(Courtesy of Prof Gayle, *Relational Communication NURS 6793* Spring 2015, University of Colorado Denver).

Such bottlenecks are likely to be at national policy such as parliament as much as in boardrooms e.g. District (County) health management teams (DHMT) and Hospital Management Teams (HMT), Unit/ward level, community health based organization meetings, village health committees.

It is my hope that the *Groupthink* theory has found its place and I believe there is a lot Kenyans have observed concerning this theory. We see these things all the time but situating them into a theory makes a lot of difference. This theory is easy to understand, it shows acuity. It became apparent that by applying Janis Irving's *GroupThink* theory it was easier to dissect this phenomenon that so easily beset us about bad decisions.

This brings to mind the saying, "that looks like it was designed by a committee" (not a compliment!). Essentially there is nothing wrong with a committee if we could add value to the terms of reference to include: gathering evidence, literature review, reviewing of data. The committee should acknowledge limitations/delimitations. Achievements to include what the committee did what it could not.

We can no longer assume that as long as good people are representing us in meetings they will make good decisions and so forth. They might be going to the meetings unprepared or casually. See **completely lost** below. I think to avoid the situation of *that looks like it was designed by a committee*, what we need is good facilitators/leadership and good team working skills.

Completely lost

I was appointed to this committee on research ethics and another one to organize an international conference in 6 months' time. As one would imagine the later was asking for more, it required attending every Wednesday for those six months and more frequently as the day grew nearer. I really looked forward to the ethics meeting, I loved looking at other people's proposals but it was difficult to give it my best, but it often happened on another day.

The venues for the two meetings was 40 Km away from my usual station making it mainly on public transport (motorcycles taxi or a probox commonly), using my own fare most of the time. I missed quite a number; I felt completely lost at times, went in casually often and was unprepared a few times. To say the least I might have been my station's best choice but I was not ably representing them one way or the other.

In a nutshell: An effective meeting should be more of a record of the way forward, not of deliberations-

- Increased operational efficiency may mean having more meetings or teleconferences. However, brief weekly meetings can be more efficient than holding on to all your questions and issues for a month or longer.
- Instead of not going to meetings. You should focus on making them better.
- Increase your benefit by making sure you attend all relevant meetings and asking insightful questions.
- Action generated against whom, what and when.
- Think though each action (identify sub-actions that cumulatively lead to achieving the main one).

- There should be no surprises (what do you expect?) what are the agreed deliverables? These are the basis of the engagement.
- An irresponsible and careless attitude in any meeting will bring disaster in the form of wasted time and resources
- Best Practices Quality Management Systems e.g. ISO 9001:2008
- Utilize templates, frameworks
- Special meetings are special and should have one core agenda and no AOBs Any Other Business (AOB's). In any case AOBs are not to be discussed in any meeting; they are fodder for members to think about, or to become substantive agendas for the next meeting.

I do not necessarily subscribe to his idea but one busy don colleague applied this principle: Try to skip meetings as much as you possible can - they are big time wasters. Ask in advance for the agenda. If there is none, look for and find an excuse. If you have to attend ask for when it ends and remind the chair that you have to leave the meeting earlier or at the stoppage time in case it prolongs.

Concerning matters arising either extreme would drain even resilient members. In one hand the chair might say *I think it's clear crystal* while on the other hand he dwells on *matters arising from matters that arose from …those previous (of previous) meetings*. Or rather, either brush out everything or sustain pending issues that kept on pending. How do we avoid all these? See below some lessons I picked from my meetings mentor:

8.7.2 My meetings mentor

One of this author's mentors was good at chairing meetings. Among other points the `following were some best practices I picked from her: At the beginning she was fond of saying, 'we want to make our agenda (or program) very straight forward… Can we agree these are the issues we are going to discuss?' Then she would ask members how long the meeting should last; proposers and a seconder on the same.

She could defer a matter if there were a number of issues that could not be answered, facts that could not be found etc. about it, she might say, 'If you say you don't have it, we should be very quick to defer, not waste time'. Then she would set deadlines, upon which the matter must be addressed, by who and report to who, by which date and eventually report during the next meeting. Most of her deadlines were astonishingly short but one had to deliver.

This was what she often said about other matters, 'let us pack it somewhere, we deal with it after this'. About emerging issues, she might say, 'we do not want to open a Pandora box, we have serious business to conduct before going that way'.

Sensing an emerging blame game she might say, 'we cannot talk about people who are not here in this meeting, the presenter has to take responsibility and follow it up himself'. Issues that appeared systemic were noted to be dealt with at a forum that could address systemic issues, which an ordinary meeting could not, that could include if need be the formation of a sub-committee.

Matters of policy were to be noted as such and dispensed off expeditiously. If there was a policy to handle this, it was not to be discussed. She might have said, 'do we have a policy about that or

we don't? That is what policies are there for so that we do not waste time dealing with every issue'. If the matter was weighty- investigate and report later against the stated policy. At one point she issued the following directive, 'we do not want stories and excuses we want an actionable report (I insist joint) on exactly what happened, leave the rest to us'.

Lastly before *Any Other Business* (AOB's) and there was still time she dealt with the packed issues during the meeting. Some of which by now may have gotten answers as the meeting proceeded. She tried to summarize, with little or no discussion. If it became clear that a discussion was necessary she would defer to the next meeting and as usual task some members to do some background check.

She liked saying, 'I want tables, my brain thinks more clearly when I see tables', and so we plotted tables on many issues. The secretariat knew what to do over breaktime whenever there was an issue being discussed, they inserted tables into what we had done and waoh! The results were better. We often took time out to allow for a table about what we were discussing. Collossal as tables were it did not take long before this values were passed on to others. The sense of ownership of the process was could I say fairer than without tables. So much for that.

I also found some odd things about my mentor. At the end of the meeting like she requested everybody to stand up to say *The Grace* (a common short final prayer) and if there was a meal she said a quick prayer, rarely did she ask someone else to pray. That aside, she appeared on top of things, was assertive but a good listener too. Apparently every other meeting she led used to be so very productive, at times it was a mystery how she managed to do that. It might be something to do with preparation and good leadership skills. 'At the end of the day, good leaders often do not do the work but they make you feel like they did' this was said by Jo Miller editor of Beleaderly and CEO Women's Leadership Inc. The few we could pick like the ones above were exceptional.

Leading by consensus will rally a team around a common goal, but according to Jennifer, that alone was not enough to be a leader and create change. 'Consensus was good but direction and decisiveness create action. Consensus must be guided'.

It would be good to mention what she said about why policy?: provides for a course of action; provides guidelines; establishes consistency; provides a standard that can be evaluated; provides at a minimum what must be done, how to resolve difficulties, omissions and commissions; provides steps; a framework to build upon in terms of areas of information, choices, training; provides for need for updates/revision from time to time to accommodate emerging issues and discard the no longer relevant; uses a common language understood by users; is made available/accessible at point of use.

Let us move a step further through a preview of a case analysis of 'The Challenger' (see **Groupthink challenger** below) borrowed from outside of healthcare. Then look through a preview of a case analysis of nursing theory to enhance the provision of quality health. For a start here is one nursing' theories link for you: http://currentnursing.com/nursing_theory/

8.8.0 Embracing theory to enhance provision of quality nursing care: A snapshot

Some nurses often times find theory intimidating, but working with theories is less daunting than many expect, the reality is that you have been working with theories of this or that all your life even if they hadn't been labelled as such.

Theories provide an abstract understanding, move beyond describing a single event by providing a means (a lens) by which all such events can be understood. For example, a theory of customer service can help you understand the poor service the customer or even you yourself (in our context the patient) received from the radiology department. The same theory can help you understand the good service you encountered last week at the mother and baby clinic sometimes ago. A theory like this one can assist the hospital in training and developing staff (Dainton and Zelley, 2015). We just looked at the Groupthink Theory in the paragraphs above. Everyday practices enriches theory and vice versa as both practice and theory are guided by values and beliefs. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques.

Theory can close the gap between theory and research and envision potentialities. “The study and use of nursing theory in nursing practice must have roots in the everyday practice of nurses” (Alligood, 2014). It guides nursing practice and generates knowledge, it helps to describe or explain nursing, it enables nurses to know WHY they are doing WHAT they are doing (Gordon, Parker, and Jester, 2001) and enhance evidence-based nursing. Another example might be why health-supporting activities inside the hospital could be carried on outside the hospital (Halie, 2000).What evidence; best practices (including theories) are there that would support this?

An observation was made by Leah Curtin (1989), a former editor of Nursing Management, was that "Practicing nurses who despise theory are condemned to performing a series of tasks - either at the command of a physician or in response to routines and policies". Margaret Newman, on the other hand, showed the necessity of linking practice with theory by saying, "We have to embrace a new vision of health. Our caring must be linked with a concept of health that encompasses and goes beyond disease" (Parker & Smith, 2010).

GroupThink: The Challenger

Shuttle Challenger on January 28, 1986. Shortly after launch, the Shuttle exploded destroying the vehicle and all crew members; These are excerpts from the analysis of the space shuttle disaster by Forrest Jeff entitled ‘A failure in decision support system': http://dssresources.com/cases/spaceshuttlechallenger/h is a good example of the dangers that flawed group decision making can result to:

National Aeronautics and Space Administration (NASA) was made aware of the problem but it was "down-played" as a low-risk situation; the decision to delay a Shuttle launch had developed into an "unwanted" decision by the members of the Shuttle team; all members … felt that they should live up to the "norms" of the group; they soon changed their presentation of objections once threatened with the possibility of being expelled from the program; a NASA administrator who was "appalled" at a company that would make such a recommendation based on the data available; Thiokol became highly susceptible to "groupthink" when they requested a break from … At this point they became insulated, conducted private conversations under high stress and were afraid of losing potential future revenue should they disagree with NASA; all parties were afraid of public and political response to another launch cancellation (there had already been six cancellations that year).

Each party began to rationalize that past success equalled future success; Individuals who departed from the group norms were signalled out as unwelcome members; Conflict management was avoided by NASA's domination of the entire meeting. NASA, at times, became very assertive and intimidating. Considering NASA's attitude, no group member or individual was willing to be held accountable for any comment or decision;

At the end of the meeting NASA, very reluctantly, suggested that they would still cancel the launch if Thiokol insisted. No response from Thiokol was made and the NASA officials could not see the expression

of "self-censorship" that was being communicated on the face of each Thiokol engineer. The ability of each member to have voted anonymously was the key factor that would have maintained the integrity of the group decision support system (GDSS) and the quality of the decision… a decision to cancel the launch would have been made. Members of the group made a decision knowing that the decision was based on flawed information. A second concern is that the decision made put safety last and operational goals first.

Only one member expressed serious concern for the potential loss of life. Open and free communication before and during the meetings was discouraged through such group dynamics as mind guarding, direct pressure and self-censorship. Individuals, who know of a situation that, unless acted upon with integrity might cause social harm, have a responsibility to contact any authority that will manage and control that situation in the best interest of the public -"Whistleblowing" by Jeff Forrester).

8.8.1 Building a case for nursing theories

Kamau, Rotich & Mwembe (2014) published an article on *Applying Margaret Newman 'Theory of Health as an Expanding Consciousness' in Management of HIV AIDS in Kenya*. They noted that it would be good to recognize that patient-as-person involved an appreciation for the patient's self-perception and expression of an illness and the recognition that the patient's illness was a unique experience, one that was influenced by the patient's attitudes, knowledge, and current personal or social context (Mead & Bower, 2000).

Kamau *et al* (2015) did a review study on *application of Florence Nightingale's Model of Nursing and the Environment in the management of Multiple Drug Resistant Tuberculosis Infected Patients in the Kenyan Setting* (Detailed information has been presented elsewhere in Chapter 9 and 10)

Two patients could have varied responses to the same illness or chronic condition due to their personality, different life experiences, and circumstances. These were some of the reasons why nurses needed to use a nursing theory in patient care. According to Polit & Beck (2012); 'Theory is the ultimate aim of science: It transcends the specifics of a particular time, place, and group and aims to identify regularities in the relationships…'

A statement by College of Nursing of University of Colorado Denver, Guidelines for Evaluating Published Research Reports (NURS 6031) Themes or Rules-of-Thumb, Item number (11) stated that: 'Other things being equal, research related to theories is more important than non- theoretical research'.

Nurse Managers in charge of nursing units are encouraged to consider adopting on a minimum one relevant nursing theory/model (Papathanasiou, Kourkouta & Sklavou, 2013) as a step towards Evidence-Based Practice. At a minimum, it is not hard to think of an experience where a theory could have been applied (even if that was not so) after getting acquainted with one. Now, suppose it had actually been applied? The difference is obvious and quite fulfilling. More importantly how accessible (even in terms of understanding) is the theory to you as a practitioner?

8.8.2 Proposal for staff training workshop on electronic library information

8.8.1 Background and justification of the workshop

We intend to hold a workshop on capacity building on Electronic Library Information Technology for staff based in this institution/hospital/….. to be held on the digital platform. The…. week of …….. is proposed as a convenient date.

The HINARI Programme was set up in 2002 by the World Health Organization (WHO) together with major publishers and it enables developing countries to gain access to one of the world's largest collections of biomedical and health literature. More than 8,000 information resources (in 30 different languages) are now available to health institutions in 105 countries, areas and territories benefiting many thousands of health workers and researchers, and in turn, contributing to improve world health.

Objectives:

1. To train hospital staff on Electronic Library Information Technology
2. To promote effective and efficient online and offline digital library usage among staff.
3. To promote literature review undertaking for appraising evidence, conducting and consuming research by taking advantage of information technology and digital resources available.

8.8.3 Anticipated Outputs:

Staff will have trained on Electronic Library Information Technology with a bias on medical library and health system which it is hoped will be multiplied and disseminated. The costs- benefits of this multiplication will be better understood by the number of staff accessing, effectively and efficiently utilizing HINARI and other data bases for research, evidence-based knowledge, consultancy and general learning.

8.8.4 Outcomes

More participation in research work and evidence-based practice (EBP). A multiplier effect of the same is expected from the trained staff (as change agents) towards their counterparts. Trained staff can act as channels for rapid adoption and continuous learning.

Diffusion of this innovation among staffs as consumers of knowledge will take place between and amongst themselves with increased online database availability and online search diversification. Staff will adopt informatics multiplication as a viable way forward since hard copy publications are expensive and inaccessible. Informatics generally is the use of ICT to communicate, manage knowledge, mitigate errors and support decision making. If you're still not convinced that an informatics infrastructure is essential to facilitate quality patient care, watch the video at the link below.

Health Information Technology: Key to Quality Improvement. (Take help of tutorial on YouTube) http://www.youtube.com/watch?v=XbtTcT4Cl_k

While online publishing is now a reality, the world is slowly moving away from publishing hard copies to printing only on request thus there are not enough hard copies of journals and periodicals to go round in most libraries today. There was a transition from physical resources to electronic resources although at a slow pace.

Additional Resources will be saved through this method in the long term. This sizeable surplus it is hoped will enable the institution/hospital… to subscribe to accredited referenced databases to increase access. It is envisioned that online library is clean and high yielding since it requires minimal investment in terms of space and paperwork.

Networking with top notch libraries worldwide would also make it possible to borrow materials at little or no fee from vendors of knowledge-based data sources. Telemedicine is a reality that makes learning interactive without the limitation of time, distance and space. Moving away from brick and mortar institutions into virtual space.

A sizeable number of staff have access to a personal computer or laptop. The emergence of smartphones and androids have also eased on portability and interfacing.

A follow up on the ability to critically appraise and apply current research knowledge for the participants will be the next step. We would wish to train a cohort of staffs from the different departments on the same in an upcoming proposal.

8.8.4Request statement

The existence of internet opens up a world of possibilities for maximizing on what is published online and even real-time consultation. Existence alone may not yield much without its effective utilization. There is almost nil or marginal costs close to zero transmit data on the internet and on the other hand, is accessed at the lowest possible cost, easy to find. Conditions for its use is something most users hardly bother to know. The HINARI PubMed collaboration has now been made available free through the World Health Organization (WHO).

In view of the above prevailing circumstances, the opportunity to have this workshop(s) will significantly make a difference in digital library use. Resource persons have been sourced from within … meaning that it will be possible to customize the service.

We therefore request for sponsorship in tune of Kshs … (In words….shillings only) from your organization. Please see the enclosures with …. budget breakdowns, programme, and list of participants.

For these, we will be forever grateful.

Thank you in advance

Facilitator's: … (Name, qualification, designation, affiliation, contact address, email)

8.8.6 Materials needed for two days workshop on electronic library information technology.

Requirements

- 15 computers with the Internet, reliable bandwidth with HINARI access code and password
- LAN intranet access for multiple users to access
- Overhead LCD, an electronic smart board monitor is preferred where available
- Modems [3G and above -Telkom®, Safaricom®, Equitel®, Yu®, Airtel®, or smartphone with hotspot android® (personal) promoting participants' BYOD (Bring Your Own Device).
- Earphone and speakers connected per computer/user (personal) promoting participants' BYOD (Bring Your Own Device)

Budget

S/No	Item	Unit Price	Total
1	CD duplication from master DV (Quality CD-R 700mb 52 x 80min) HINARI Measure DHS	20 x Kshs… 20 x Kshs…	…./= …./=
2	Flash disks 2GB per participant	20 x Kshs…	…/=
3	1 GB airtime data per participant	20 x Kshs…	…/=
4	**Writing materials** Notebooks Pens Pencils Rulers	 20 x…/= 20 x …. /= 20 x …. /= 20 x …/=	 …./= …/= …/= …/=
5	Graph books	20 x …/=	…/=
6	Spring Files	20 x …/=	…/=
7	**Refreshments** Lunch 10'oclock Tea 4'oclock tea	 20 x …/= x days 20 x …/= x days 20 x …/= x days	 …./= …/= …/=

8	**Honoraria for facilitators**		
	….. (chief resource person)	…./= x 2 days	…./=
	…..(IT support resource person)	…/= x 2 days	…./=
	One Computer Technician	…/=x 2days	…/=
	Secretarial services	…/=x 2days	…/=
	Contingency at 10% of subtotal		…/=
	TOTAL		**…./=**

8.8.7Programme

Venue(s): Computer lab, exhibition stand. Refreshments/meals (where….) Date:

DD/MM/ YYYY

Day 1

Facilitator's name:

Technical team lead by: ---

8am -9a.m: - Registration

-Group norming

-Setting up

9am -10am: Introduction

10am –10.20am: Health Break

10.20am -10.50am: Hinari PubMed Module 1

10.50 am-11.20am: Hinari PubMed Module II 11.20am-

11.50am: Hinari PubMed Module III 11.50am -1pm

Quizzes + exercises Searches

- Internet profile

1pm-1.15pm.A message from the sponsors: …., Visit to the exhibition stands at own pleasure.

1.15pm – 2pm Lunch Break

2pm – 2.30 pm- Hinari PubMed Module IV

Interrogating Health Systems

2.30p.m -3pm- Hinari PubMed Module V 3p.m

- 4p.m - quizzes + exercises

Internet services 4pm

- 4.20pm- Health Break. 4.20pm –

5pm -Group work

Day 2 DD/MM/ YYYY

Facilitator's name:

Technical team lead by:

8.00am -9.00am -setting up

–recap on previous day's

9.00am - 10am -group representation on topics and searches so far

10.00am -10.20am - tea break

10.20am - 10.50am -introduction to reference management tools e.g. Mendeley, Zotero

10.50am -11.20am – Overview on Integrated DHS measure, Google Scholar, Open Data Kit .

11.20am --11.50 am quizzes + exercises

Internet searches

11.50am - 1pm Miscellaneous topics

Library search skills (online)

1.00 pm-1.15pm - A message from the sponsors, Visit to the exhibition stands at own pleasure.

1.15pm - 2pm lunch

2 pm -3 pm Groups' refined topics

Presentations Plenary

3.30pm - 4 pm Closing and award of certificates of participation

Setting up of a peer research team
Prologue

8.9.8 List of participants

Name, designation, department, email address, phone

8.9 Closing remarks on EBP

To choose one model or theory from the other, look at what resources you have and what you intend to accomplish in the end and see which one looks like it will take you down the path of least resistance. Strategies to maintain consistent, reproducible employment of EBP in patient populations and practice areas throughout the network requires utilization of standardized EBP implementation tools such as the Iowa Model.

Nurses need to promote best-practice outcomes, as they are the experts who recognize, through experience, education, and clinical judgment, when a practice is inappropriate, outdated, or targeting the wrong patient population. How could EBP models/frameworks, nursing theories benefit our practice?

We must step up our practice, Think Big, Act Small, Start Now! Small efforts here and there and in this way questions that may not have immediate answers in resource-constrained settings can be thought through.

I have never forgotten what one John Kabanya, a pharmacist commented during a Funzo-Kenya workshop at KMTC Nakuru in November 2013:

"When you come up with a budget, the boss will ask you where the money will come from. Tell him this. 'I have partners who are going to assist me'. He will ask you whether you have talked to them, say Yes. He might say but you have not talked to me! Don't ask your boss to give you the money. Tell him that you want to assist him. Discuss the solutions you are proposing to a problem you have. Remember that you have to propose solutions, otherwise, you are wasting his time"...

My final thoughts on EBP and research bring us to the next vital component - helping health care providers' access evidence. Even within existing financial limitations, access to research data bases should not be seen as an afterthought or an add-on after everything else has been done. On the other hand, the data we generate should no longer remain unshared, unpublished and essentially wasted. It should be possible to create as a minimum a memory that captures the knowledge stored in peoples' heads. Our hospitals and higher education institutions must become learning organizations.

Evidence is available from databases through performing a literature search, appraising evidence and consuming research. I have a problem with the approach that the research is taught in many learning institutions (at least where I have been). Students are taught research methodology with the emphasis being to conduct research as though it was like 'picking low hanging fruits' which it is not while infact it means climbing up and taking on the riskier branches.

On the other hand learning how to consume research would be picking the low hanging fruits. Data created from research are valuable resources that can be used and reused for future scientific and educational purposes. Shared data facilitates new scientific inquiry, avoids duplicate data collection and provides rich real life resources for education and training.

This is an upside down approach in my view. If indeed research must be done then we are sure there is no tangible evidence to be found anywhere or at least the need for the rigorous

activity that research is necessary as the only way out and can be supported. Wouldn't it be better that our students first and foremost become skilled at literature searching, appraising research, becoming consumers of research?

Figure: The three aspects of appraising evidence



In other words, encourage readership of research work and where there is need conduct research. No wonder we are unable to implement even our own findings into practice because either they are not actionable or pragmatic enough or were derived from less than adequate evidence.

Worse still was the principle of ownership of the research. It may have been conceived by someone else or someone else did the research for and on our behalf (thanks to the proliferating academic writing business hubs. The largest concentration used to be housed along University Way, Nairobi among others). All some candidates needed was some coaching to enable them to defend 'their' research before a panel. The passion may be lacking. Al-Riyami (2008) wrote the following in an authoritative review article entitled *How to prepare a research proposal:*

Health research, medical education, and clinical practice form the three pillars of modern-day medical practice. As one authority rightly put it: 'Health research is not a luxury, but an essential need that no nation can afford to ignore'. Health research can and should be pursued by a broad range of people. Even if they do not conduct research themselves, they need to grasp the principles of the scientific method to understand the value and limitations of science and to be able to assess and evaluate results of research before applying them (Dr. Asya Al-Riyami was the Director of Research & Studies, Directorate of Research & Studies, Directorate General of Planning, Ministry of Health, Muscat, Oman).

Researchers were embracing social media even in their collaborations on primarily scientific forums. *Your Newsfeed on Mendeley is a great place to see what's trending*, both in your network and in the wider world of academic research. You'll be able to:

D Discover and follow interesting people in your research field

D Stay up-to-date with connections and see what's trending in your network

D Keep in touch with colleagues and leading researchers.

Reputable science research journals had Facebook links as well as blogs e.g. *PLOS* has a blog to capture diverse perspectives on science and medicine. They call it Translational Global Health is an international blog focusing on key knowledge and implementation gaps in Global Health – from latest scientific evidence to policy and population health impact. Articles are both commissioned and *crowdsourced*.

Your scientific reputation is not only measured only in peer-reviewed publications. Your scientific blog posts, your tweets, your contributions in forums, all this will grow your reputation (Julio Peironcely, in the Next scientist blog).

Deriving a publishable paper from the research is another challenge. Few learning institutions subscribe to credible databases. A lot of students simply Google and come up with whatever stuff related to a topic. My take on this is that as long as the approach is to have the student conduct research without first inculcating the more important consumer value, then the essence of why research and evidence-based care will not take root.

At least for health care staff, the need to consume research is more important than conducting the research itself, but then they are not well grounded in these skills. I have attached here below a proposal that the reader can adapt on training a team on online literature searching.

Resource persons can be gotten from reputable libraries. Some staff who have advanced post-graduate education might be helpful too. I say - some staff because a reality check would likely find that even in some of the medical institutions of higher learning, a number of teaching staff (some teaching research) may be lacking in this vital component or are not researchers themselves in the first place.

When it happens that the only research (es) one ever did was *as partial fulfilment for the award of a degree* then that would not be good enough. We need to do much more as Kenyans scholars and health care providers if EBP will get us to where we ought to be as we strive for excellence in whatever we do. Draw upon the best evidence to provide the care most appropriate for each patient (Institute of Medicine, 2008). That way the quality of health care provision would move a higher notch.

Bedside nurses in a number of studies wished someone would collect and synthesize the evidence for them and convince them of its benefit before they will adopt new practices (Yoder *et al.,* 2014). Do we even have such persons in resource-constrained settings? Whichever the answer may be, as long as access to the library (including online library databases) was limited and even such exists staff do not use or consult them, EBP and innovations will take a back seat.

Mostly, staffs stuck to what they knew and what they did. Thus the importance attributed to the bedside leadership role cannot be overstated. I believe as part of nurses' professional growth and survival we need to grow more "in the trenches" leaders! The bedside is where the action is! It is the perfect vantage point to be a positive change agent for healthcare delivery.

Using library search engines is not easy either. It would be unrealistic to expect them to add these activities to their duties. Off course there would be little time to search during a shift and compensated time out would be needed with a lot of administrative input that creates a culture of EBP and research utilization. Nevertheless, my take on this is - if as Kenyans we have plenty of time to be on social media that is more than enough 'quality' time to skim through a standard research article.

According to Johns Hopkins Nursing Evidence - Based Practice Model and Guidelines (Sigma Theta Tau International, Indianapolis; 2007) - Evidence-based practice (EBP) is a problem-

solving approach to clinical decision making in a healthcare organization that integrates the best available scientific evidence with the best available experiential (patient and practitioner) evidence, considers internal and external influences on practice, and encourages critical thinking in the judicious application of such evidence to care for the individual patient, patient population, or system.

There are many models for EBP, but they all include 5 distinct steps: (1) asking important questions, (2) acquiring the evidence, (3) appraising the evidence, (4) applying the evidence to practice, and (5) assessing the results and adjusting the processes if needed[60].

The following background notes were gleaned from Quality and Safety Education in Nursing (QSEN). Evidence-based care integrates best current evidence with clinician expertise and patient/family preferences and values for delivery of optimum health care:

The nurse will identify efficient and effective search strategies to locate reliable sources of evidence. Learn to critically appraise original research and evidence summaries to an area of practice. Exhibit contemporary knowledge of best evidence related to practice. Initiate changes in approaches to care when new evidence warrants evaluation of other options for improving outcomes or decreasing adverse events.

Analyze how the strength of available evidence influences the provision of care. Develop guidelines for clinical decision making regarding departure from established protocols/standards of care. Value the need for continuous improvement in clinical practice based on new knowledge. The big question remains: So how can we get over the stigma of – it's a nice idea – to using evidence in our daily practice?

Educators in nursing and other health care disciplines must prepare them to appreciate the research and to participate in its design, implementation, and evaluation at the level of their preparation. Practicing nurses of all cadres and levels must actively seek to develop and adopt EBP protocols. Institutions must support this effort. Health care leaders must facilitate a conducive environment that fosters intellectual pursuits and supports research efforts.

Collaborative arrangements between hospitals and faculty must be developed for such activities as student projects, continuing education, coming up with clinical practice guidelines, protocols, and research endeavours. Consumers of healthcare need to be educated about the value of health care research. Policy makers want to be informed of pertinent findings so that results can be translated into health policy. The next few chapters concern utilizing theory and evidence based inpatient care.

[60] Evidence-based behavioral-practice. Steps for evidence-based behavioral practice

http://www.ebbp.org/steps.html

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CHAPTER 9

Utilizing Theory and Evidence to Deliver Care I:

Applying Margaret Newman's Theory of Health as Expanding Consciousness *to Psychosocial Nursing Care of HIV-Infected Patients in Kenya*

Chapter co-authors: Simon Macharia Kamau, Rose Jelagat Rotich, David Juma Mwembe

Overview

Margaret Newman's Theory of Health as Expanding Consciousness is considered a grand nursing theory, she described a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world. Newman's theory proposed that: Health is not lack of illness, or a process to become healthy from being ill, but it instead of the expansion of consciousness as a result of choices made within the context of patterns of behaviour.

Nurses in Kenya have mostly used the psychosocial-medical model to nursing HIV-infected patients which fail to answer many of the nursing concerns and reduces their autonomy in carrying out nursing care. Indeed the pride of the nursing as a profession is anchored on its regulatory tools and the ability for self determination.

Methodology: This mini-review was an evolving emergent design. Slightly adapted *Advanced Theory in Nursing* coursework materials were used. The greatest resource was referrals to links and hints as offered by those who got interested in the study. A best case scenario is appended. Conclusion: Newman's Theory of Health as Expanding Consciousness is, therefore, a generic tool applicable to guide psychosocial nursing care of clients infected with HIV. It would be a great resource with a potential to evidence-based nursing care. It would provide a basis for several case studies. Nurses find more fulfilment in their work by utilizing a nursing theory.

9.2. Background

Anecdotal evidence shows that nurses involved in the care of HIV-infected patients in Kenya have mostly used the psychosocial-medical model whose primary focus is on the diagnosis and treatment of symptoms and disease. This fails to answer many of the nursing concerns and reduces their autonomy in carrying out nursing care.

For example, many HIV-infected persons have high levels of depressive symptomatology, as well as suicidal ideation and hopelessness being increasingly reported, usually upon knowing their seropositive status or precipitated by the progression of the illness [1]. How would the nurse best handle these concerns? A Theory (or a combination of theories) might come as a handy relief

9.3 Why Theory

Everyday practice enriches theory and vice versa as both practice and theory are guided by values and beliefs. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques. Theory can close the gap between theory and research and envision potentialities. "The study and use of nursing theory in nursing practice must have roots in the everyday practice of nurses" [2]. It guides nursing practice and generates knowledge, it helps to describe or explain nursing, it enables nurses to know WHY they are doing WHAT they are doing [3] and enhance evidence-based nursing. Another example might be why health-supporting activities inside the hospital can be carried on outside the hospital [4].

What evidence, best practices (including theories) are there that would support this? "Practicing nurses who despise theory are condemned to performing a series of tasks - either at the command of a physician or in response to routines and policies", an observation made by Leah Curtin, a former editor of *Nursing Management* [5]. Newman, on the other hand, showed the necessity of linking practice with theory by saying, "We have to embrace a new vision of health. Our caring must be linked with a concept of health that encompasses and goes beyond disease". The theory of health as an expanding consciousness provides this link.

As we introduce this theory it's good to recognize that Patient-as-person involves an appreciation for the patient's self-perception and expression of an illness and the recognition that the patient's illness is a unique experience, one that is influenced by the patient's attitudes, knowledge, and current personal or social context [6]. Two patients can have varied responses to the same illness or chronic condition due to their personality, different life experiences, and circumstances. These are some of the reasons why nurses need to use a nursing theory in patient care.

According to Polit referred to in [7], 'Theory is the ultimate aim of science: It transcends the specifics of a particular time, place, and group and aims to identify regularities in the relationships…' A statement by *College of Nursing of University of Colorado Denver*, Guidelines for Evaluating Published Research Reports (NURS 6031) Themes or Rules-Of-Thumb, item number 11 states that: 'Other things being equal, research related to theories is more important than non-theoretical research'.

9.4. Theory of Health as Expanding Consciousness

Margaret Newman's Theory of Health as Expanding Consciousness (HEC) posits that "every person in every situation, no matter how disordered and hopeless it may seem,is part of the universal process of expanding consciousness – a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world" [8].

Newman wanted to move from the reductionist model of 'health is the absence of disease', and develop a model that would articulate the essence of nursing practice. Health within illness dichotomy may not be a readily accepted concept. This theory considers illness as an opportunity for awareness and growth. 1t also shifts the focus of health care from fighting the enemy of illness to learning about oneself through the illness experience.

The concept of consciousness as defined by Newman is the informational capacity of the system (in this case, the human being); that is, the ability of the system to interact with the environment. Consciousness includes not only the cognitive and affective awareness that is normally associated with consciousness but also the interconnectedness of the entire living system that includes physiochemical maintenance and growth processes as well as the immune system [8].

9.5. Assumptions

Newman held the view that *Health as an Expansion of Consciousness* (HEC) is based on five assumptions [9]:

1. Health encompasses conditions previously viewed as pathology,
2. "Pathology" can be a manifestation of the total pattern,
3. Pathology may exist as a manifestation of a pattern that exists prior to the manifestation of physical or structural changes (manifesting as pathology),
4. Removal of the pathology does not change the pathology, and
5. "Illness" maybe be the only way an individual's pattern can manifest, and as such that is health for that individual we

We wanted to add a sixth assumption that, 'The tension in illness can allow patterns of expanding consciousness to emerge'.

9.6 Concepts

Some of the concepts of this theory are; 'The theory of health as expanding consciousness (HEC) was stimulated by concern for those for whom health as the absence of disease or disability is not possible'. Nurses often relate to such people: people facing the uncertainty, debilitation, loss and eventual death associated with chronic illnesses.

The theory has progressed to include the health of all persons regardless of the presence or absence of disease --asserts that every person in every situation, no matter how disordered and hopeless it may seem, is part of the universal process of expanding consciousness – a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world [10].

9.7 Propositions

The theory proposed that: Health is not lack of illness or a process to become healthy from being ill, but it instead is the expansion of consciousness as a result of choices made within the context of patterns of behaviour. Although this theory can be abstract and challenging to grasp, one of the main strengths of this model is that it addresses the patient and their choices, experiences, and state of health (and unhealthy) as a whole [11].

9.8 Application to Practice

Kenya has been battling with HIV/AIDS since it was recorded in 1984, HIV infection has spread very rapidly in the country and the magnitude and impact of HIV/AIDS is a major public health and development challenge. It was estimated that more than 1.5 million Kenyans were infected with HIV about 400,000 undiagnosed and that over 1.5 million Kenyans had died of AIDS and AIDS-related with some regions recording as high as 14% of their population as having the virus [12]. Estimates show that the undiagnosed figures could be higher.

> A diagnosis of HIVAIDS can be devastating to persons and their families as they face a multitude of physical, emotional, spiritual and social stresses from the effects of treatment, changes in lifestyle, disruption of home and family roles, and fears of stigma. People infected with HIV are challenged by changes in their endurance and strength, reproductive capacity, sexuality, and self-image, as well as their own mortality. It is often asserted that AIDS is at the core of a "vicious circle", whereby the impacts of AIDS increase poverty and social deprivation, while poverty and social deprivation increase vulnerability to HIV infection. This is especially true for resource-constrained settings like Kenya.
>
> For the newly diagnosed HIV-positive client just as Newman referenced in [13] they learn that "each day is precious and that the time of one's life is contained in the present." The adverse effects of stigma were all-encompassing in terms of feeling of health and wholeness. There was need to know that simply having a disease does not make a person unhealthy.

One of the persons living with HIVAIDS put it this way, ‘we need to be free from stigma because that is all that kills’. One could experience health and wholeness in the midst of having a chronic and progressive disease, before and even after CD4+ T cells levels prognostic indicators signify need to initiate ARTs and opportunistic infections (OI's) medications.

We tended to relate this with Martha Rogers (Newman stated that *Roger's theory of Unitary Human Beings* was the main basis of the development of her theory) who had said earlier that health and illness may not be two separate realities, but rather as a unitary process. Rogers' Science of Unitary Human Beings puts the key thesis of the model as The individual is a unified whole in constant interaction with the environment; nursing helps individuals achieve maximum well-being within their potential… in that people can experience health even when they are physically or mentally ill.

Nursing must find ways to care creatively for patients. Holistically to encompass the whole person, not just a body part or system. We need to emphasize this at every opportunity and during their appointments to the *Comprehensive Care Centres* (CCC). Indeed health is not the opposite of illness, but rather health and illness are both manifestations of a greater whole.

One can be very healthy in the midst of a terminal illness as long as they maintain a healthy mind-set, positive self-image, eat well, involved in social support, avoid

reinfection and adhere to treatment among others. We have a saying here in Kenya that, 'One is either infected or affected by HIV'.

It was to be assumed that at least every Kenyan knew someone who has it. In some regions of this country, people know entire households that have been wiped by the virus. Not long ago it was not possible for people to own up in public disclosures about their seropositive status.

We now have people living with HIV (PLWHA) for over 27 years and are apparently healthy. Discordant couples were still a big dilemma for us even as we endeavor to move towards elimination of mother to child transmission of HIV (*e*MTCT).in sub-Saharan Africa by December 2015[14].

Beyond Zero worked hand in hand with other organizations as the National Organization of Peer Educators (NOPE). NOPE worked by using rapid response initiatives whereby they link the newly diagnosed HIV-positive persons to the nearest health facility for management. NOPE targets 90.90.90 i.e. they had to test 90% of the population; link 90% new cases to the health facility and 90% were expected to have a low viral load within 3 months of treatment.

An important realization by Newman was that (orientation to - emphasis *ours*) time, movement, and space was in some way interrelated as parameters of health. Every remaining faculty must be appreciated especially during the times of diminishing health or terminal stages.

Some people have realized new strengths unknown to them before the diagnosis with terminal illnesses; one Asumpta Wagura had achieved exponential feats [15]. Her motto goes like 'Do not take life for granted. Celebrate it'. She has been a beacon of hope for people living with HIV/AIDS (PLWHA). She was the Executive Director of *Kenya network of women with AIDS* (KENWA). Many people look forward to Asumpta's *Diary* in Wednesday's edition of The *Daily Nation*, One of Kenya's leading national newspaper.

Time is a treasure for the HIV-infected persons, they can make a choice on how best to use it to gain maximum returns in terms of their future and that of their children by making realistic goals based on the life expectancy. Increased insight into the meaning of their experience and the meaning of health can be realized when the client and the carer(s) connect in their new roles in health during counselling and social support.

The theory applies to the nursing today because of the increasing emphasis on continued care outside of the hospital. Whereas health-supporting activities inside the hospital can be carried on outside the hospital, a lot of social support and empowerment is needed. *Home-based care* has been shown to reduce the workload of the health care providers and lowers the economic burden of rural/local health care centers to care for HIV/AIDS patients [4]. But home-based care as taught in nursing curriculum is a new concept in Kenya although it had always been practiced in the African traditional cultures (see Chapter 14 on lay care providers).

The patient needs to be psychologically prepared for the recovery at home and to accept this as part of his/her medical/nursing history now. Helping them understand that this is not temporary but will be the norm will help them get the available resources they need to

function. While home nursing does not seem readily appealing to the nurses in Kenya, it would in a big way '…bring out the significant caring manner witnessed by the power of nursing presence in the patient's usual surroundings' as was proposed by Newman.

The patient needs to acknowledge the issue before anything can be done about it. Acknowledging and accepting it will lead to this new wonderful consciousness (expanding consciousness) where help can enter the patient's life. In this new consciousness, the nurse needs to involve the patient in the nursing care plan. Define what their goals are, whether they are new or still the same goals, and how to get there.

Newman talked about making deliberative observations about patients and reflecting what she observed back to the patient. This specific attention stimulates patients to respond by talking about what was meaningful in their unique circumstances and their subtle needs. From our experience(s) and as seen in the case study below, HIV-infected persons really appreciate this: they wish to connect with self, interpersonal and the community in a holistic sense to achieve a greater sense of health. The point is; if you can get a patient to identify their goals and then give them tools to achieve those goals, that patient can continue to help him/herself and transcend" their current state, adds Newman.

The meaning of the new seropositive status and illness will need to be understood within the context of the patient's entire life, not just his/her physical state (whether ill or just HIV positive). This way a path towards health becomes apparent to the patient. The eventuality (about full blown AIDS) can be postponed but it will catch up with time.

The patient will be prepared in advance on what to expect as CD4+ T cells counts start going down significantly and AIDS sets in '… and if becoming "ill" is the only way a person's pattern can be manifested, then be it! That is health for the person' adds Newman. This process of focusing on meaning in patients' lives to understand where the current health predicament fits in the whole of people's lives has endured as central to the Theory of Health as Expanding Consciousness.

We felt that the following Newman's quote, though a paradox in light of public health, holds some truth; "[t]he responsibility of the nurse is not to make people well, or to prevent their getting sick, but to assist people to recognize the power that is within them to move to higher levels of consciousness" [12].

There is an increasing interest in personal transformation during illness. Case studies from clinical practice illustrate the potential contribution of 'shared consciousness' or..... For Newman, a disease is a meaningful reflection of the whole and health is 'expanding consciousness' in assisting people to use the power within them. The two (illness and health) are thus seen as a continuum.

9.8.1 Case Study Mrs Y.

Utilizing Margaret Newman's theory through a case of a family experience of HIV/AIDS in Kenya "This is a case of Mrs Y, a 32-year-old female, a resident of the Kericho County in South Rift region of Kenya. She is a housewife and the husband is a small scale farmer. She has married a mother to eight (8) children; four boys and four girls, all alive.

She tested HIV positive in 2002 but the husband was HIV negative to date. She started using antiretroviral (ARV) drugs eight years ago when her CD4's were 250. The family had been enrolled with Walter *Reed Project* (WRP is an NGO Supporting HIV/AIDS patients- through, counselling, testing, medication and food supplements for free. The project is a partner with PEPFAR (Presidential Emergency Plan for AIDS Relief).

The rest of the children were negative apart from the last born who was seven months old and now sickly. All the 8 children were born in a hospital, 4 after they knew their status.

Mrs Y has been in and out of the hospital since 2006 with complaints of chest congestion, oedema, difficulty in breathing and fatigue. Most notably her health has been down with every subsequent pregnancy. On the other hand, Mr.Y has been undergoing a series of regular laboratory tests but remained HIV Negative. The couple verbalized appreciating their support for one another despite their status view life positively for the sake of their children who are unaware of the health status of either of their parents.

Furthermore, the health care team have been helping them especially when they are admitted. The nurse at the Comprehensive Care Centre utilized the components of Margaret Newman's theory of Health as Expanding Consciousness to assist Mrs Y in pattern recognition so she may understand new possibilities for action; that in illness, there is room for health. Expanding consciousness around her illness helped her see that within the confines of her disease, she could enjoy aspects of health. Illness was not something that "happened to her", but was a part of her life's pattern.

Nurses have had a wider role since they are the patient every other time which enabled them to win the couples' trust and confidence leading to a therapeutic nurse-patient- relationship over the years. Weekly visits by a home-care nurse includes- assessments of her weight, blood pressure, Vitamin B12 injections and reviewing medication adherence.

The home-care nurse also identified the potential for increased interaction with others and an increase in consciousness by triggering the understanding of new possibilities for action. To recognize past patterns of relating and how present circumstances have changed those patterns.

Something interesting the couple once said was '…the best medication for the patient with human immunodeficiency virus/acquired immune deficiency syndrome is acceptance of the status'. They added nutrition and adherence to antiretroviral medication regimens as very important.

They recognized psychosocial support as a means of coping among those with HIV/AIDS, Mrs Y. belongs to a peer group, she says '…it has proved to be thoroughly effective'. Here they emphasize on *get tested, start treatment early and have annual viral load tests apart from living positively*. Previously she had also felt that she did not want to 'feel like a burden' to anyone. However she adds that most of her long-time friends have since passed away, she says these were mainly those with the very little social exchange.

Mrs Y represented over 2.2 million people Kenya living with HIV/AIDS (PLWHA). Kenya's population was 40 million people by 2009 census. An early

step for the discordant couple in HIV preventive counselling on behavioural risk assessment was done to the couple as high-risk individuals.

Her health had taken a nosedive in the last few months. She had become debilitated and sick with side effects from ART therapy. She was unable to work, play with her children or keep up the chores around their home. Were it not for the help they got from the Walter *Reeds Program* all their financial resources were but exhausted, they were running low on all including groceries.

She said she was able to face her death with pride and dignity. She felt that she had continued to live and enjoy her children as much as possible. She had provided real hope and encouragement to others experiencing an HIV/AIDS diagnosis. She made the following comment close to her death, "I may be dying of AIDS, but I feel healthier than I have ever felt".

9.9 The Future

There were various writings on Margaret Newman's Theory of Health as Expanding Consciousness [10, 13, 17] posits that humans cannot be divided into parts, but are inextricably whole beings. Health was central to the theory "and is seen as a process of developing awareness of self and the environment". That "Consciousness is a manifestation of an evolving pattern of person-environment interaction" and that consciousness is an on-going process. This author felt that sometimes manifestation of a problem could be mistaken for the problem itself, therefore one needed to be careful.

The author also felt that the theory of Health as Expanding Consciousness (HEC) helps direct nursing in supporting patients of today and if integrated with current social media technologies like Web 2.0, will be one that will prove useful well into the future. For example, a social platform like "Patients Like Me" [16] was designed to help patients encourage others beginning the journey, find support with others who were dealing with similar conditions.

Taking *Health as Expanding Consciousness* literally these technologies really can support patients in "finding greater meaning in life and of reaching new dimensions of connectedness with other people and the world". Nursing can help patients navigate to such resources that will support them through their health experiences. Theories like Dr. Newman's will offer direction on how to find consistency in supporting patients in an ever changing landscape of knowledge and care.

9.10. Conclusion

Margaret Newman's Theory; expanding consciousness is a process wherein an individual becomes more of his/her real self, as he/she finds greater meaning in his/her life and the lives of those people around him/her. Self-awareness may eventually lead to acceptance of one's self and one's circumstances and limitations. Newman's theory of pattern recognition provides the basis for the process of nurse-client interaction. She suggested that the task in intervention is a pattern recognition accomplished by the health professional becoming aware of the pattern of the other person by becoming in touch with their own pattern.

Humans cannot be divided into parts, but are inextricably whole beings. Health is central to the theory "and is seen as a process of developing awareness of self and the environment" (Newman, 2010). Consciousness is a manifestation of an evolving pattern

of person-environment interaction" (Newman, 2013).This consciousness is an on-going process.

Therefore, we submit that Margaret Newman's Theory of Health as Expanding Consciousness (HEC) is a generic tool that would be applicable to psychosocial nursing care of clients with HIV in Kenya and elsewhere. It is, therefore, a great resource. Several case studies based on this model would be possible. Nurses would find more fulfilment in their work by utilizing a nursing theory. Hopefully, readers will be directed to seek further information, some of which are contained in the links below in order to fully appreciate the utility value of this approach to nursing care. A home page referred in [17] would be a great place to refer.

Nurse Managers in charge of nursing units (including CCC's) are encouraged to consider adopting on a minimum one relevant nursing theory/model [18, 19] as a step towards evidence-based practice. On a minimum, it is not hard to think of an experience where the theory could have been applied. More importantly how accessible (even in terms of understanding) HEC is to you? How can it benefit your practice?

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Chapter 10

Utilizing Theory and Evidence to Deliver Care II

Applying Florence Nightingale's Model of Nursing and the Environment *on Multiple Drug Resistant Tuberculosis Infected Patients in the Kenyan Setting*

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Fig: 'The Lady with the lamp' (Courtesy of clip developer)

10.0 Overview

Nursing has a long and valued history of using evidence to impact practice, beginning with the earliest pioneer, Florence Nightingale (Nightingale, 1859). Nurses in many resource-limited settings have mostly used the medical model which failed to answer many of their concerns in managing tuberculosis-infected patients.

Florence Nightingale's Model of Nursing and the Environment states that nurses manipulate and mediate the environment to put the patient in the best condition for nature to act upon. Nursing theory and models have been recognized as key components to evidence-based practice today. Every nursing unit in developed countries employs at least one. Kenyan nurses need to realize this and embrace this principle.

This chapter begins by expounding a commonly known, but not always well-understood model by the founder of modern nursing, Florence Nightingale. Methodology: The current study was a review and it applied Florence Nightingale's Model of Nursing and the Environment on drug-resistant tuberculosis-infected patients in Kenyan. The format of this review was completed by using the authors' adapted "Advanced Theory in Nursing" coursework materials.

Secondary sources and seminal works by the theorist were also scrutinized. A case scenario was embedded that was somehow typical to maximize what could be learned about this theory. Conclusion: Nightingale's model is a generic tool applicable to guide nursing care of clients infected with multiple/extremely drug resistant Tb with potential to improve nursing care and provide a basis for case studies.

10.1. Why Theory

Due to the changing and challenging nature of nursing, various theories and philosophies have been advanced to guide nursing practice, education, and research. It has been said that everyday practice enriches theory and vice versa as both practice and nursing theories

are guided by values and beliefs [1]. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques. Theory can close the gap between practice and research and envision potentialities. While proposing her idea of practice theory, [1] provided the following concise description of a substantive theory:

"It is a theory that says; given this nursing goal (producing some desired change or effect in the patient's condition); these are the actions the nurse must take to meet the goal (produce the change)".

According to Heartland National Tuberculosis Center [2], nurses who happen to be new to Tuberculosis control and prevention face multiple challenges including a) learning the basics of tuberculosis infection and disease diagnosis and treatment and b) gaining problem-solving skills essential to Tb case management.

The general practice nurse is the first line of defense in Tb control worldwide, and this important role needs to be recognized and strengthened [3]; one way would be through nursing theory-guided practice. "Practicing nurses who despise theory are condemned to performing a series of tasks—either at the command of a physician or in response to routines and policies", Leah Curtin, a former editor of Nursing Management made this observation [4]).

It was evident from literature [4] [5] that there was a gap between nursing theories for practice as taught in the classroom and actual nursing practice. Many nurses especially in resource-limited settings like Kenya had little or no knowledge of nursing theories as a basis for practice and did not knowingly apply nursing theories to practice. The literature further suggested that some of the theories as taught were inappropriate for practice in the African context [5].

According to Owino [5], there was apparently no evidence of published studies on practice outcomes of Nursing theory utilization in Kenya then, and this seemed to hold true four years later today according to us (the authors of this article). These were observations by Owino et al., a Kenyan nurse who developed a grounded theory Owino's Theory: Nurse-Client Interaction for Childbirth Preparedness Analysis and Evaluation; just referred to as Owino's Theory [5].

10.2. The Theorist

Florence Nightingale (1820-1910) was bestowed with several honours: OM [(order of Merit (commonwealth)], RRC (Royal Red Cross), Honorary Freedom of the City of London. She came to prominence for her pioneering nursing work during the Crimean War where she tended to the wounded British soldiers. An Anglican herself, she believed that she was called to be a nurse. Though living in the 19th century she was endowed with premodern feelings and modern ideas, which remain quite relevant today.

She laid the foundation of modern nursing [6] [7]. Her work has influenced many other disciplines including mathematics, writing, public health, medical tourism, heath care legislation/ reforms, medicine, hospital architecture and the church.

She is one of the most celebrated, written about character through biographies (there are more than 300 Nightingale biographies and 16 volumes of her writings), art, theatre,

poetry, and museum [7]. Queen Victoria wished aloud that she had Nightingale in her cabinet. Nursing schools, babies, buildings, and streets were named after her [8].

10.2. Introduction to the Model of Nursing and the Environment

10.2.1 Analysis:

o Nightingale's concept model is overlapping with discrete concepts. o

Model is still applicable to practice today.

o Model is simple and easy to understand.

o The model requires the nurse to use knowledge in addition to "artistic"

oAllows intuition and personal caring to aid in patient health.
viewpoints.

Nightingale emphasized that the person had a key role in his/her own health and that health was a function of the interaction between person, nurse, and environment. The major assumption was that nurses concern was with the person in the environment and the person interacting. The laws of health as defined by Nightingale were those to do with keeping the person and the population healthy. She indicated that proper use of fresh air, light, warmth, cleanliness, quiet had the least expense in terms of vital power.

She believed in a "healthy house" in order to prevent illness and promote wellness. Two of the elements to a healthy house that were emphasized in her theory were fresh air and sunlight. *The health of houses*, as she prescribed, were the administration of each or all of these: ventilation of patients' rooms and the larger environment, light, cleanliness, punctuality, eating of food and interpersonal milieu.

The patient's capacity for self-healing was facilitated by the nurses' ability to create an environment conducive to health. Nurses, on the other hand, manipulate and mediate the environment to put the patient in the best condition for nature to act upon, concerning this she said, *"what nursing has to do… is to put the patient in the best condition for nature to act upon him"* [9]. Nurses must also be protected while they care for others [3].

5 essential elements to a "healthy house": clean air; clean water; proficient drainage; cleanliness; light.

10.2.2 Assumptions:

o Nurses should be educated and trained in the field and care of patients.

o Nurses should focus on environment and how to manipulate it to put patients in the best possible state to achieve health and healing.

o The environment is essential to the health of the patient.

o Nursing and medicine are separate.

o Nursing is a science and an art.

10.2.3 Strengths:

o Nightingale's Model of Nursing and the Environment is easily adaptable, as well as applicable, to all patient care settings.

o Model and theory's meaning and purpose are easily understood.

o Nightingale's writings are easy to read and understand regardless of the difference in time period and changes in terminology over the years.

10.2.4 Limitations:

o Nightingale's environmental theory does not directly discuss the effects of the environment on patients' psychological health.

o The theory is limited but it is still effective.

10.2.5 Controversies:

Among some of her beliefs, here are a few that we found interesting and though we felt some would not be a reality in today's healthcare:

1) Noise—she stated patients should never be waked intentionally or accidentally during the first part of sleep.

Counterargument: Today on night shift patients are woken up multiple times per night for vital signs, medications, labs etc. Patients are lucky to get two to three-hour stretches of sleep during the night.

2) Variety—she believed in varying colours from flowers to plants and even rotating paintings on a regular basis.

Counterargument: Hospital rooms are neutral colours and are lucky if they have a painting or a working wall clock on them. If there are flowers (or a card for that matter) in the room, they are from family, not provided by the hospital. There is actually very little "variety" in the hospital.

3) Nutrition and Food—she vowed that no business be done with patients while they are eating because that is a distraction.

Counterargument: In most cases, patients are on "hospital time" when they are in the hospital and we distract them often as they eat.

4) Her philosophy about nursing as a calling. Treating a patient was priceless. However, she may not have meant "calling" in a religious sense but having a kind

of feeling for one's work—an inner sense of what is right, which she termed "enthusiasm," from the Greek ethos, having a god within.

Counterargument1: some people do not agree that nursing is a calling with; fewer wanting to play some of the roles she modelled for women-the obedient wife, caring sister, modest daughter and her feminist ideals (emphasis ours). B.N. posted on *Enlightening Nurses* on social media on 15th September 2017, 'Love for your work should not blind you not to see what you deserve … Even a calling deserves logistics…' This was during the nurses' strike in Kenya which lasted over three months. Some nurses felt that it was therefore wishful thinking to assume it was a calling. It was more realistic to appreciate that nursing was a calling, a career or a mixer of both.

Counterargument2: If you would not do something without being paid, you should not do it just because you are paid. You should likely do nursing because it is your passion and by exploring it, help others. Any other reason, it will come off as inauthentic and you risk damaging your therapeutic nurse-relationships or employer employee relationship among others. In other words to me (this author) this would be an easy way to screen out misfits in any profession early enough.

Counterargument 3: Brittney & Kati (2017) described making money through blogging, that some nurses struggle with the guilt about making money writing about nursing. In the following quote I have replaced the word *content, blogging* with *care and nursing*. 'Many people are idealists and believe that nurses should provide free high-quality *care* out of the kindness and desires of their hearts. Financial gain from their *care* is an absurd thought to them.

It would be wonderful if we could all feed our families and pay our mortgages with kindness and good intent, but the world simply doesn't work that way, doing *nursing* out of the kindness of our hearts is impractical in the short run and damaging in the long run'. Adding, 'We all enjoy being nurses and taking care of patients, but it is a career; it is not a hobby. No one expects you to work a shift for free. We should be compensated appropriately for not only our time, but our expertise as well. Do not sell yourself short … realize that your expertise is valuable and needs to be considered well'.

Continuing Brttiney & Kati's line of argument, they observed that *there were so many talented online influencers that were either making no money, or barely enough to enable them to continue providing value*. Same with nursing care providers.

5) She was against a standardized nursing licensing exam and felt that an individual should be evaluated on their character and morals.

Counterargument: This would be rather odd today, no nurse can practice without first passing a board exam and get state or national body license. Continuing Professional Development (CPDs) for nurses in Kenya is a pre-requisite for renewal of the practicing certificate every 3 years. This is in recognition of the fact that knowledge and skills depreciate over time, and that new technology and public health issues are dynamic

10.2.5 Symbolism of *The Lady With The Lamp:*

The lamp is an international nurse symbol that is widely known to symbolize Florence Nightingale and her transforming work in the nursing profession. Her lamp became synonymous with goodwill, reliability, and compassion, which are all attributes that are highly desirable in the field of nursing today. During many pinning ceremonies, new nurses often hold up lamps and recite a nursing pledge, which is another nurse symbol that is associated with Florence Nightingale.

The pledge, which is adopted from the physician's Hippocratic Oath, is based Florence's ideologies and promises to be compassionate, uphold a certain code of ethics, and keep patient's information confidential**.** nerdy nurse *Nurse Symbols: The Origin and the History* Published: July 25, 2017.

Counterargument: Some people assumed that the head cap gear worn by nurses was synonymous with (or rather replaced) the lamp in the later days. A good number of nurses nolonger adorned the cap or else did not allign themselves with much of the nurses' symbolism. The nurses' pledge is still administered today to new graduates although it be not with the same sentimental value.



Fig: Florence Nightingale left symbolism in nursing
(Courtesy of the clip developer)

10.3 Nursing and the Environment:

Adapted from [6] [10] focuses on the patient while manipulating the environment. Nursing and the environment referred to several things: the "health of houses"; prevention of illness; promotion of health; observation of sick; "healthy house"; attention to nutrition; attention to patients and their needs.

10.3.1 Concepts

o Ventilation and warming (clean air)—Should be the first and last thing that nursing should fix. Air that the patient breathes should be pure, fresh and warm.

o Clean water—water should be sanitary. Sewers should be kept separate from drinking water, and water should be purified to prevent illness

o Drainage—pipes and sewers should drain effectively. In Nightingale's time, this was a real issue.

o Cleanliness—Open windows, clean dust, dispose of waste properly, clean linens, carpets, and floors.

o Light—dark houses are unhealthy and poorly circulated. Sun and light were essential for proper healing of patients.

o Nursing aids in the ability of a person to maintain health and to heal, by managing the environment.

o Frequent observation and individualization per patient were necessary.

o Nursing encompasses observation and management; the environment encompasses ventilation and warming, and the health of houses.

o Nurses are to manipulate the environment and manage health. This directly affects all the concepts in Nightingales model.

10.4. Tuberculosis

Tuberculosis is a serious communicable disease. Tb control was challenged by the HIV epidemic, it had shown improvements, and with key indicators such as Case Notification, Case Detection, and Treatment Successes all showing improvement before HIV came into the scene. HIV and Tb formed a lethal combination with each speeding the other's progress. From then on tuberculosis was ranked second only to HIV/AIDS among the infectious agents with highest mortality rates worldwide, 8.6 million people fell ill with Tb and 1.3 million died from it. Over 95% of these deaths occurred in resource-constrained countries. Tb remains the leading killer of people living with HIV [11] [12].

10.4.1 Drug-Resistant Tuberculosis

The emergence of drug-resistant Tb since 2005, particularly among males, has been a key challenge. Extremely drug resistant tuberculosis (XDR-Tb) is a form of tuberculosis caused by a strain of Mycobacterium tuberculosis a gram positive bacterium that is resistant to isoniazid and rifampicin as well as any Fluoroquinolone and any of the

second-line injectable anti-Tb drugs. When new strains prove too clever for the two most powerful first-line drugs isoniazid (INH) and rifampicin (RIF), multiple resistant tuberculosis (MDR) emerges, these drugs that were once effective become worthless against this strain of tuberculosis.

Drug Resistant-Tb is confirmed through laboratory tests that show that the infecting isolates of Mycobacterium tuberculosis grow in vitro in the presence of one or more anti-tuberculous drugs. Two different categories of drug resistance have been established: Mono resistance is resistance to only one anti-Tb medication while Poly-resistance involves two/more drugs other than the combination of Isoniazid/Rifampcin (INH/RIF).

Access to quality second line drugs as well as laboratory capacity for second-line drug susceptibility testing presents a formidable challenge for programs in low resource settings in Resource-Constrained Settings. Quality second line drugs are expensive, less available take longer, even up to two years, with a high likelihood of drug toxicity, further resistance and defaulters [11] [12].

In 1993 the WHO declared Tb a global emergency. It was interesting that even though only 10% of those exposed to Tb became infected, one-third of the world's population were infected with the bacterium that causes Tuberculosis, meaning that one-third of the world's population had latent TB, which meant they have been infected with TB but aren't (at least not yet) ill with the disease. Out of 3.7% of new Tb diagnosed cases were multiple drug resistant (MDR-Tb) with a relapse rate of approximately 20%.

Former Soviet Union countries ranked the highest with cases of extremely drug resistant tuberculosis (XDR-Tb) worldwide. Kenya was ranked 13 in the list of 22 categories of "high Tb burden" countries worldwide. According to WHO, Kenya had an estimated 2300 cases of multiple drug resistant (MDR-Tb) in 2007. Current figures by National Tb and Leprosy Program, Kenya, there were 15 new multiple drug resistant (MDR-TB) cases are diagnosed monthly in Kenya.

This information was released during the world Tb day marked on March 24th, 2015. World Tb Day served to promote advocacy for prevention, screening, and treatment of tuberculosis. "TB has no borders, anyone can contract Tb. The healthy, the young, no one is immune" [13]. *Get tested; Get treated; Get cured* in the mulika & maliza spotlight on Tb campaign.

One in ten of all MDR-Tb cases is extensively drug resistant (XDR-Tb). Resistance often develops in areas with poor Tb control programs where: Tb treatment was poorly managed when patients do not complete their full course of treatment, when incorrect dosages were prescribed or when there was a break in drug supply [11] [12][14].

The African Region accounted for over 80% of the Tb cases among people living with HIV and since higher mortality from MDR-Tb and XDR-Tb had been documented in HIV-positive patients [11]. Some of HIV patients were co-infected with MDR, XDR Tb, therefore, collaborative activities were widely implemented [12] [15].

In Kenya, patients have free access to diagnosis and Tb treatment services from public health facilities under the National Tb and Leprosy Program (NTLP). Ordinarily, Tb treatment under directly observed treatments (DOTs) had two phases: an intensive

(initial) phase, which comprised the first 8 weeks for new cases and twelve weeks for retreatment cases, and a continuation phase of 4 - 6 months immediately following the intensive phase [12].

Involving community volunteers

Hospital co-works with Community Health Volunteers [CHVs] and Community Health Extension Workers [CHEWs]. Cough monitors were community health volunteers (CHVs) who have been trained how to identify those people who they come across who are coughing; where possible inquire the length of coughing and make early referrals to chest clinic for early diagnosis. They would also escort them and became contact persons in case of follow-up. Each worker was encouraged to build a deep personal connection with every person in their jurisdiction. Mark you these are not health professionals talking to the community members, they are community members.

They helped to demystify Tb diagnosis and treatment - that the regime had become more user-friendly, shorter. *Gene expert* test required one sputum specimen and was very accurate (higher sensitivity & specificity to Tb diagnosis and drug sensitivity testing than smear microscopy). Emphasize coughing hygiene, good ventilation, avoiding overcrowding and good nutrition. They were also useful in defaulter tracing. Refer for investigation cough of any onset.

In the National Tb and Leprosy program (NALEP), trained CHVs in Siaya were able to refer people suspected to be having early signs of leprosy. In the first one month after training at least 10 of those referred were positively diagnosed at the Alupe Leprosy Centre in Busia County. With patients eyes closed, by utilizing a very simple technique fine touch sensation over the lesion patches with *whiskers of a star grass*, contrasting the same with areas without patches. The patient would report *if he had been touched and where*. He reported not having been touched in the areas with the lesions! Leprosy is, early enough to treat before deformities and other complications caused by the disease had occurred. The leprosy bacterium spread the same way as the Tb, same factors in prevention and control. Leprosy, however, was a more neglected disease, but perhaps more common than previously thought.

Moi Teaching & Referral Hospital (MTRH) in Eldoret, Kenya had a standard model in the management of MDR-TB according to WHO Green Light Committee on management of MDR/XDR Tb [16]. WHO established the *Greenlight Committee* in the year 2000. This committee works with programs and pharmaceutical companies to secure the necessary drugs at 99% less than the open market price. It cost an average 1.2 Million Kenya Shillings (an equivalent of 10, 200 USD) to treat one patient with resistant Tb according to [17] [18] WHO 2014 estimates.

The Moi Teaching & Referral Hospital (MTRH) in Eldoret, the second largest hospital in the country in 2010 reported that 79% of notified Tb patients tested HIV positive and 37% of HIV positive Tb patients were accessing Highly Active Anti-Retroviral Therapy (HAART). By then the centre had 11 multiple drug resistant Tb cases (six of them on home care) and 1 extremely drug resistant Tb patient (the only case known in the country then) who was being managed in the isolation ward.

10.5 Application of Theory to Practice

The Isolation wards and the homes where drug-resistant Tb infected patients were managed need to meet the 5 essential elements to a "healthy house" namely: clean air; clean water; proficient drainage; cleanliness; light.

Nightingale talked about observation as a reliable means of obtaining and verifying knowledge. One of the key determinants of Tb management success involves high level of case detection which goes with keen observation.

Nightingale was frequently seen making rounds and documenting observations at night carrying an oil lamp thus she was fondly referred to as *"Lady with the Lamp"* [19]. Tb treatment is a strict six-month drug regimen provided to patients with support and supervision to ensure adherence through directly observed dose therapy (DOTS)—an observer watches the patient swallow the medicines for adherence and side effects management [3].

The growth in mobile phone penetration (estimated at 8 out of 10 Kenyans by mid-2017) had created new opportunities to reach and improve care to underserved, at-risk populations including those with tuberculosis (TB) or HIV/AIDS. Mobile phone penetration was estimated at 35.5 million by early 2017. Remote Mobile Direct Observation of Treatment (MDOT) for TB patients. The MDOT model combines Clinic with Community DOTS through the use of mobile phone video capture and transmission, alleviating the travel burden for patients and health professionals [37].

With MDR-Tb infected patients usually at 3rd to 4th month of treatment, sputum should have converted to negative. Conducting routine drug susceptibility testing for all TB cases allows early identification of drug resistance in the population at greatest risk. Utilizing a patient centred nursing process approach, case finding and patient holding as highlighted in the International Council of Nurses (ICN) manual in many ways recognized Nightingales emphasis on strict observation and documentation.

Nightingale did a lot of documentation of her thoughts; her memoirs form a solid part of the history of modern nursing (Florence Nightingale, Notes on Nursing 1860/1969) as well as influencing other fields such as advocacy, health care policy, statistics, and public health. Nothing can take the place of monitoring and evaluation in the management of Tb. Just like Nightingale did, keeping a journal, logging in and proper documentation of Tb issues by the nurse and to some extent (emphasis ours) through some training of the client are necessary competencies. She underscored the critical role of outcome documentation.

Monthly Tb reports have to be submitted on or before the 5th of each month upwards from 1st level (community) to facility level—Sub County—County-National Tb and Leprosy program (NTLP) to the global level [20]. Data is analyzed to give vital statistics. This way we can monitor the clients at risk of developing MDR/XDR Tb and pre-empt it where possible.

Nurses must constantly do evaluation and reassessment to ensure appropriate care at each stage to enhance the patient's adherence to Tb treatment protocols. Nightingale argued using statistics, to prove that decreasing mortality would cost less money… for patients to heal translating into what we would now consider as evidence-based practice [7].

She ably plotted a polar pie chart on the Crimean battle hospitals mortalities significant decline (from 42% to 2%) as result of her interventions (mainly by improved hygiene, and advocacy by calling upon the British Sanitary Commission). Charts continue to be a visual way of understanding data we still use to show prevalence rates, new cases, Tb progression to non-infective condition; sputum conversion from smear positive to smear negative.

In some parts of West Pokot County in northern Kenya, a whole village could be Tb infected: with 800 new TB cases diagnosed annually and a Tb prevalence rate of 223 per 100,000 and a Tb incidence of 85 per 100,000 (the projected County population in the year 2012 was 562,845 people) and 42 nurses per 100,000 persons [21]. Alupe Sub-County Hospital's Leprosy Centre in Busia and Tb "Manyattas" (some kind of isolation traditional dwellings within the villages of Sigor region of West Pokot County) have retained their utility value among the communities. Every year they receive thousands of medical tourists.

10.5.1 Applying Model of Nursing and the Environment in control and prevention of Tuberculosis

The anti-contagionism view which Nightingale apparently subscribed to postulated that some diseases were communicable and could spread by pollution of the air we breathe.

> Counterargument: Contagionists, on the other hand, believed diseases only spread through direct contact, something Nightingale opposed. She did say that sufficient levels of contaminants could induce endemic or epidemic ills. Tb is mainly transmitted by droplet airborne from person to person supporting the anti-contagionism viewpoint. Undetected cases continue to transmit since a person only needs to inhale a few of these organisms to become infected. This knowledge comes in handy when we consider cough etiquettes—avoiding risky behaviours like spitting, discouraging open coughing, use of disposable tissues, spitting into tight fitting sputum mug, proper sputum disposal (bio-hazards) by burying or burning. Observation of universal precautions, Infection Prevention Practices and Control Protocols (IPPC), hand washing, provision of additional antiseptics such as hand sanitizers [22].

In anti-contagionists' view; in order to prevent the spread of Tb to others, it was advisable to avoid overcrowding (e.g. church etc.) for Tb this would be until sputum conversion from +ve to −ve. To avoid contact time with other clients it is necessary to reduce waiting time through triage.

Some African cultures encourage relatives to stay in when their significant other has been hospitalized, however, it's discouraged for lay caretakers to stay overnight for an MDR/XDR Tb patient and in any case, N95 masks must be worn by all attending to including visitors [22]. When there happened to be Tb in one of the adults, there was a likely risk of household exposure to children and other relatives. For children the effectiveness of vaccination against the disease was critical.

Those who are in close contact for sustained periods of time are most at risk and these are often the children of those with the disease. WHO reported that in 2013 about 53 million children under 15 were living with latent TB infection, a condition that can develop into active Tb at any time [22]. Findings suggested that about 7.6 million children younger than 15 in 22 "high burden of Tb" countries became infected in 2010. Of these nearly 651,000 developed the disease [18] [23].

Fresh air and light as advocated by Nightingale play a key role in Tb care. Tb bacterium is sensitive to light and does very well in stuffy poorly lit rooms. As much as possible patient is to stay outdoors. The rooms must have wide openable windows. She emphasized importance of variety since the "nerves of the sick suffer from seeing the same walls, same ceilings same surroundings". The need for an outdoor, pleasant surroundings, sunlight, and fresh air perhaps meets this goal.

A good example that contravenes Nightingales principles were prisons in Kenya. They are extremely congested such that the holding grounds which were meant to have 500 inmates might have four times that number. Tb thus is high among inmates. Prisoners in cells shared the same poorly ventilated air for extended periods of time, and movement within the prison was limited to some limited perimeter. Prisoners found that it was a big privilege to be allowed some few minutes of sunlight per day, one politician claimed "some prisoners were locked in the cells for months without seeing the sun" Kenya National Assembly Official record [24].

One of the strategies used during Nightingale's time was quarantine. To keep the disease away from non-infected areas. The management of XDR Tb will remain a challenge as there is no effective treatment and isolation for indefinite period could raise human rights issues. Nevertheless, for MDR/XDR Tb we need to isolate those who meet stringent criteria such as non-adherence, refugee camps. Kenya is host to the largest refugee camps in the world of about 630,000 refugees in Dadaab and Kakuma. In May 2016 the Kenya government ordered the closure of Dadaab refugee camp in Garissa County for what it cited as security reasons.

Another common problem that might be mitigated by admitting patient into the isolation ward is that of long distances the patient has to cover to reach facility (on average most are 5 to 10 km away or further for nomadic communities). Even at home, a separate room for the patient is advisable during intensive phase of treatment [12] [20].

Kenyatta National Hospital (KNH) had closed the isolation ward for some years and it took some activism and media report to have it repossessed from the Nairobi Hospice in September 2014. This was significant in the wake of the Ebola threat that had seriously affected a number of West African countries of Liberia and Sierra Leone among others. Reports by Save the Children International [25] indicated that in Sierra Leone a “terrifying rate” 5 people were getting infected with Ebola virus disease every hour which overwhelmed the country’s health care system.

The experience the staff had gained would be called upon in the wake of *Chikungunya* virus outbreak in Mandera County in June 2016. This is a mosquito-borne disease, the mosquitos biting usually during daytime, and could be prevented by wearing long-sleeved clothing and covering exposed parts, sleeping under long lasting insecticide-treated nets (LLITNs) and spraying the breeding sites.

Out of the 600 people, 10 of them were health care providers who got infected in their course of duty, it was further reported that by June 1st, 2016, 70% of the population of Mandera County was infected or hospitalized due to either cholera or *Chikungunya* virus. Several schools had closed. The situation was aggravated by lack of clean running water in health facilities and the town in general. There was also fear of a yellow fever outbreak in the region, spreading from neighbouring countries of Ethiopia and Somalia where some cases had been reported. A response team led by the Cabinet Secretary, Ministry of Health visited the area to assess the situation.

The Nightingale model advocated for proper diet selection and administration. Tb patients usually have poor appetite, some of the drugs they take also cause them nausea and vomiting as side effects. Therefore a collaborative food drug plan is necessary: eat pleasant healthy balanced diet, modified where necessary of affordable locally available food, drink only safe water. Just as Nightingale advised on monitoring of patient’s expenditure of energy, regular

anthropometric measures monitoring like weight and body mass index are done as most Tb patients tended to waste away. Indeed weight gain was an important prognostic indicator for Tb.

Going back a little more on the concept of ventilation; ventilation of dwellings was a key concept in Nightingale's model [26]. She wrote, "I do think that the feeling of fresh air and warm sunlight on patient's face raises their spirit and has an effect on the psyche. The lack of which has also contributed to delirium in some hospitalized patients". Preferably we should have natural lighting and where possible fit UV lights into the room.

Tb patients experience night sweats and need pure fresh air which is circulating adequately, perhaps what Nightingale had in mind. In the rural areas and much of the informal (slums) settlements in resource-limited settings, the houses are overcrowded and many lack windows. The traditional African hut had one or two "peeping" holes, which acted as windows. The hut is commonplace wherever one goes into the rural Africa. Many people do not have separate room for fireplace. All these compromises on ventilation.

Successful tuberculosis treatment depends on more than chemotherapy and requires specific clinical and social frameworks based on an individual patient's circumstances [27]. Interpersonal milieu was referred to in the Nightingale model [28]; the role of the community in—psychosocial support to encourage patient to finish treatment, social support (i.e., assistance and emotional support from others); active case finding; cough monitors; management of contacts—tracing, follow up/visiting patients home every 3 months for 24 months to ascertain close contacts even the asymptomatic ones. In case of defaulter tracing, visit patient's home within 24 hours.

In the public/private sector mix, there are now stickers on public transport in Kenya commonly known as "matatus". One read: "Stop Tb, open windows for air circulation". The Preferred mode of transport for Tb patient is the "bodaboda" namely bicycle or motorcycle seat-taxis.

> A higher education institution with a health campus in Kenya for years had this middle aged driver of a 62-seater bus who had very poor coughing and spitting etiquette. He drove nursing, clinical medicine, environmental health students among others on a regular basis for clinical work and field work. It was later confirmed that he had defaulted Tb treatment twice. A section of the management was aware of his being unfit for the job long before this but did not take necessary precautions. The fate of the ?Tb contacts unknown as yet.

Some ideas for incentives to motivate the patient to adhere to treatment are known to be effective and enhance the patient/nurse relationship: support groups; award ceremonies on successful completion of treatment; reimbursement for travel, food, visits, and reminder alert reminder phone calls [3] [12].

10.5.2. Applying Model of Nursing and the Environment on advocacy

Nightingale left us the legacy of connecting caring with activism [9]. Florence Nightingale wrote, "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle" [29]. Activism in primary caring promotes

exposing, provoking, and unbalancing the social power that maintains people in a state of disease, while simultaneously nurturing caring [30].

> Counterargument: 'There is the right way and the wrong way to do things and there is a wrong way to do things. The processes and protocols and even how to go about being in advocacy was not all that clear' (*words of wisdom* by Weatherby F. RN, PhD, University of Oklahama). One needed to be careful even if the cause was noble lest one found themselves defenseless and on their own.

When she was nearing the end of her life, Florence Nightingale said: "May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done" [31]. Further "All the results of good nursing may be spoiled or utterly negatived by one defect, viz.: in petty management, or in other words, by not knowing how to manage that what you do when you are there, shall be done when you are not there." This excerpt from, "Notes on Nursing" by Florence Nightingale. This was possible if nursing leadership could get together and, rally nurses around an issue. She reiterated on the need for boldness "... how little can be done under the spirit of fear".

It is worth noting that just as MDR Tb is a relatively new threat to health it is an entirely man-made phenomenon resulting mainly from badly organized Tb-control efforts and poor therapeutic practices of the past. Activism provides the knowledge and means of redressing the social inequalities that maintain an environment of disease [30]. Activism and political reform in Tb care today can be seen in the following scenario:

In October 2011, an HIV-infected Nairobi woman was diagnosed with XDR-Tb while already receiving her treatment at the Kenyatta National Hospital for MDR-Tb. Treatment was provided by the hospital; however, she was prescribed three additional medicines that she had to buy herself, to supplement the regimen. Following a public outcry over the handling of the patient's case, the government stepped in to pay for all her medication [32] [33].

Mismanagement of Tb treatment is the primary cause of resistance therefore uninterrupted drug supply is a must. Pointing out the need for bold policy decisions urging the government to invest in country's Tb program: equipping to diagnose, treatment and care of XDR- patients in Kenya. Sometimes in mid-2016 anti-TB drugs were out of stock in public hospitals. Efforts to mop up rural health facilities for slow moving or idle stocks did not yield much.

The current anti-Tb regimes were likely to be dead stocks in private pharmacies hardly to be found in any of them. An original brand of *Rifampcin,* previously the drug used to treat Tb and also Brucellosis in human used to cost like Kshs 200 per tablet almost ten years back. What options did the patients have? NONE! Everything possible must be done to ensure effective case detection and treatment success by well-run control programs otherwise MDR-Tb will become a major public health problem worldwide [33].

High turnover of health care staff including those in central Tb units is one of the main challenges to Tb control. Nurses working with patients infected with MDR/XDR or even suspect Tb need to be educated about the occupational risk, best-practice recommended methods of protection as they take care of Tb infected patients and should have HIV tests regularly. Those found positive do not work there but opt to work in less risky environment. There is a high demand for training of health care

workers in this area [3]. The relatives often lacked the necessary knowledge and skills about how to support and care for sick at home. Women in Africa often share a disproportionate share of care giving than men.

If the reader happens to be coming from developed countries, it would be fair to state that there are disturbing "standard" third-world conditions where majority of our patients live. This is where the pavement ends. Uncertainty was a fact of life in many a patients' environments: for example, the fact that there is lack of hot, running water; that the toilets do not flush; that the mosquitoes are malaria-ridden. Even as they stand up for the rights of the patients, most nurses and families of health care providers in many African states were living in very basic conditions and could not access quality medical care for themselves.

If indeed fear of being ostracized for being Tb infected is real then the stigma for MDR/XDR Tb infected is worse. Serious health disparities with majority of the population not having any form of medical insurance. The professional or lay care giver often times learns how to thrive in these prohibitive contexts e.g. how to "perform care with nothing" which might mean anything from doing without some necessary protective gear to having to improvise on some basics. Nightingale worked in worse surroundings, so we can do better.

10.6. Case Study

Scenario—Mrs F. Chepkemoi (not her real name) is a 61 y/o female who has been admitted for acute confusion, dehydration, wasted, urinary tract infection, malnutrition, and wound care. The patient is widowed, mother of two grown up children lives on her own in single rented room at Langas Estate, Eldoret. Was brought to the Emergency Department after a neighbour checked on her and found her in that state.

Subjective—Patient complained of itching and of being thirsty, unable to eat. Has had fever and night sweats, weight loss, and productive cough.

Objective—Patient has poor hygiene and appears to be restless.

Significant past medical history—had a history of Pulmonary Tb, declared cured on Catt 1 (notes indicated she had 2 cultures and 2 smears consecutively negative converted). She was HIV negative.

Assessment—Vital signs are: B/P 90/60, HR 110, T 39.8˚C, RR 34, SO2 87%, Patient alert and oriented to place and person only. Pale +, Skin tenting, mucous membranes dry. Red and raised rash to extremities, stage II pressure ulcer to coccyx. Lymphadenopathy axillary nodes, Weight 44 Kgs, Height 5'1". The patient is ambulatory, unsteady gait noted. Respiratory system: difficulty in breathing, reduced chest wall movement the right side with coarse crepitations. Chest X-ray showed bullous lesion, with right lower lobe consolidation. Sputum smear positive. Culture and sensitivity later showed resistance to INH and Rifampcin.

*Suspec*t—MDR-TB.

Plan—Care for her in the isolation unit for the first 3 months and do observed dose therapy. Administer IV fluids and medications as ordered. Start Regimen Step 1 to 3 agents. Schedule nutritional consult with dietician.

Establish hygiene care routine. Social services evaluation for living conditions assessment. Routine skin assessment and wound care. Handle the issues of myths on the threat of MDR-TB that might lead to stigma such as "it is incurable", but nevertheless control the number of contacts. Turn off fluorescent lighting and use natural light and lamps for patient comfort. The isolation ward was a prototype in the manner of Nightingale's "healthy house": proficient drainage, clean air, no dust, adequate ventilation, natural light. After 3 weeks fever had subsided, patient had gained weight and anorexia had improved. The case was an ongoing concern by we were writing this chapter

10.7 Conclusion

The general practice nurse is the first line of defense in Tb control worldwide, since Tb (including MDR-Tb) is a treatable and curable disease. This important role must be recognized and strengthened [3]. One way is through nursing theory-guided practice. We therefore submit that Florence Nightingale's Model of Nursing and the Environment is a generic tool that would be applicable to nursing care of clients with MDR/XDR Tb in Kenya and other resource-constrained settings. It is, therefore, a great resource. Several case studies based on this model would be possible.

Hopefully, readers will be directed to seek further information, some of which are contained in the links below in order to fully appreciate the utility value of this approach to nursing care. A link like these ones [26] [34] [35] would be a great place, to begin with. Nurse managers in charge of nursing units (including Chest Clinics and Tb units) are encouraged to consider adopting on a minimum one relevant nursing theory/model as a step towards evidence-based practice. According to [38] 'nursing, nightingale and beyond is a picture of struggles, success, and potential solutions to the predicaments surrounding the nursing profession'. It was a virtue to keep Nightingale lamps ablaze.

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CHAPTER 11

Utilizing Theory and Evidence to Deliver Care III

Nurse Managers' Perceptions Towards Their Roles in a Resource - Constrained Hospital Settings

Overview

This is an excerpt from a wider study on job description of nurse managers by this author. Aimed at describing the experiences and perceptions of nurse managers towards the various factors that affect their roles as nurse managers in the hospital. Being a nurse manager is a unique skill. It requires wearing two hats: that of a caregiver and that of a leader who can implement and adopt innovative ideas to improve patient outcomes or else 'Speaking out for nursing. Speaking out for health'.

Methods: This was a descriptive phenomenological peer research design, drawing lived experiences and perceptions of nurse managers. The study was done in February 2012 in a 600-bed public hospital in Kenya, purposively targeting all the 16 consenting nurse managers working in the institution: 13 took part in the mixed study, 6 in the focus group discussion and 2 in the face to face in-depth interview. Experiences and incidents collected became the unit of analysis into 5 key points.

They were subjected to secondary analysis resulting in this qualitative report. This phenomenon was subjected to a modified Abraham Maslow's theory of motivation.

Results:

Problem Recognition: Nurse as an employee, awareness of the demanding job, reflecting. Reflexivity on the part of the peer researcher. Some respondents disagreed that the job was satisfying to them. Some apprehension was obvious.

Commitment: Accepting the role, altruism, duplicating and reciprocating. All respondents agreed that they did work that someone else was supposed to do.

Exhaustion: High expectations, lowly appreciated, stagnating but not redundant, wearing out, frustration. Lack of recognition, supplies, and equipment came out strongly as limiting factors in the performance of their complex roles. The nurse managers felt generally overworked and were not paid in commensurate.

Discussions: There is great need to clearly outline the nurse managers' role in the hospital as their job description. Their roles were either complex, multidimensional or both. There is a need to equip the nurse managers with leadership skills.

11.0 Background

The nurse manager is responsible for development and supervision of nursing services in a division/department/unit managed by senior nursing officers. The nurse manager's job is key in facilitating patient care and in ensuring the quality of work life of the nursing fraternity. The nurse manager is given the responsibility to accomplish specified goals for the organization they work for [27]. The manager must communicate a strong belief in the nursing team's contributions towards the goals of the organization. Fennimore & Wolf, (2011) on *Leveraging the Evidence and System-Level Support* came to the observation that the nurse manager was the defining role, crucial to the achievement of workplace outcomes. This agreed with [1; 20; 24].

'Evidence links NM leadership to nurse satisfaction and retention, professional practice environments, employee engagement, use of research, and patient quality and safety' -Dr. Nora Warshawsky has extensively studied NM [21].

The American Organization of Nurse Executives (AONE) developed the *Nursing Workforce Model* to assist in understanding the complexity of the nursing workforce. The model is based on Systems Theory [28] originally defined by Peter Senge (1990).

The *delivery systems domain* of the Nursing Workforce Model recognized that:

-The best way to organize the delivery of care was still a dilemma

-There would be increasing demand for healthcare services and with increasing acuity

The *work environment domain* recognized:

-Rigid structures that lack the capacity to be flexible and innovative stifle the work environment and discourage nurses who see ample opportunities to improve care processes. Flexible work schedules were a common component of many family responsive human resource policies. This covered a number of flexible work arrangements such as allowing employees to adjust their time of reporting and leaving work within certain limits. Work schedules are flexible and may vary from week to week or day to day.

According to Nursing Workforce Model, the right setting for providing care as well as the appropriate staffing and differentiation of roles for that setting were increasingly important for nurse managers.

Further, AONE also came up with: The Nurse Manager Leadership Collaborative Learning Domain Framework (NMLC) outlining the three domains- the Art, the Science and the leader within (see figure below)



Fig: The Nurse Manager Leadership Collaborative Learning Domain Framework

(Used with permission)

According to Prof. Anna Karani, a renowned Kenyan nurse researcher, educator, and writer; the shortage of nurses is acute in many countries, and there seems to be little hope of a quick change in this situation. It is therefore essential that this scarce resource is not only appropriately trained, but also creatively deployed. The first step in achieving these objectives she said would be to understand exactly what the demands are [2].

Hospitals in Kenya and indeed throughout the region are in the midst of significant and even dramatic changes including embracing the Quality Management Systems model (ISO 9001:2008). The impact of these changes on the role of the nurse manager is just beginning to be identified and` research in this area is limited [3].

Kleinman studied nurse managers and made this observation, "nurse managers are often less well prepared to manage the business activities than the clinical activities" [4]. While [5] commented this about nursing from the Kenyan setting that, '…studies have shown that nurses are management, preparing and monitoring budgets, managing upward to senior colleagues, and using technology in everyday practice burdened with non-nursing duties which take away time which could otherwise be used for the core functions of nursing'.

Nurses are often appointed into the position of managers based on their clinical expertise, but they often lack confidence in topics ranging from human resource. One peer social media [6] (www .nursetogether.com) by nurses pointed out this reality, 'Nurse manager is sometimes a role that is thrust upon a nurse because nobody else wants the job…'

According to Ginette Rodger, then Chief Nursing Executive of Ottawa Hospital, in a positional statement christened - *NursingLeadership 2002* in Canada, 'leadership is the most pressing issue for the profession to act on' [7]. The WHO Nursing and midwifery Strategy 2016-2020 show the need to empower the nurse manager as a global agenda. In September 2017 it held a meeting in Bosey Switzerland to address the missing link between the nurse manager and the nursing unions, the boardroom etc.

Globally, the International Council of Nurses supports leadership development through projects like the Leadership for Change action learning program, locally through National Nurses' Association of Kenya (NNAK) [8].

11.2 Justification

Motivation for this study came from the author's (a nurse manager himself) concern for his own roles, perspectives, and needs which may have had implications on his performance in general. This led to concern about other nurse managers.

On more than one occasion the Chief Nurse of the study site had asked the nurse managers to come up with a job description for themselves, only one out of the 16 nurse managers submitted hers'.

It was an official requirement by QMS ISO 9001:2008 in this study area that every nurse manager be issued with a job description. This was as far as it went; being issued with one. As to whether or not it was cognizant with the job demands of the nurse manager was another thing all together. The issued 'JD' as was popularly known fell short of defining the scope. Reports, literature, book reviews and policy reviews from the wider inventory study [9, 10] offered an even wider scope with seemingly never-ending expectations on the nurse manager. This ironically left the nurse manager with 'no job' description so to speak.

These others emerged as the study progressed and it came from the respondents themselves and I quote, 'You have reached a new milestone in your life -you've become a nurse manager. In your role, you now wear two hats - that of a nurse and caregiver and that of a nurse leader'. 'How do I become effective in my role?' 'Do I have what it takes to make important leadership decisions, to manage the litany of concerns that I may face in your nurse manager role on a day-to-day basis?'

11.3 Objectives

1. To describe the experiences and perceptions of nurse managers towards the various factors that affect their roles as nurse managers in the hospital

2. To conduct an inventory into the job description of nurse managers in resource-limited setting

Scope:
American Nurses Association (Nursing Administration) and Standards of Nursing Education and Practice in Kenya

11.4.1 Literature review

Online search: English language, MeSH- Key terms: nurse manager, nurse leadership, job description, resource-constrained setting, and nurse administrator. MeSH stands for Medical Sub-Headings.

- HINARI PubMed freely accessible in low-income countries
- CINAHL (Cumulative Index to Nursing and Allied Health Library)
- Modifiers: Boolean, wild card
- Google - tags
- Dissertations
- Conference papers
- Local library for hard copies of nursing journals
- Referrals
- Polit & Beck (2012) a resource for methodology

section Materials were critiqued & synthesized for relevance

11.5 Methodology

Peer to peer (P2P) - a shared view between participants (nurse managers) and researcher added to the study's 'authenticity' and honesty (Polit & Beck, 2012, Conroy, 2003). The researcher was a former nurse manager. The reader is also directed to see http://www.shu.ac.uk/_assets/pdf/hccj-ResearchMethodology.pdf.

Potential advantages of *Peer to peer phenomenological* [11] design include - ease of access, ease of recruitment, and the ability to get particularly candid, in-depth data based on pre- established trust and rapport[11; 20].

Another potential advantage is the researcher's ability to detect subtle nuances that an outsider might miss or take months to uncover.

The phenomenological researcher asks: what is the *essence* of this phenomenon as experienced by these people and what does it *mean?* Its main focus is a person's perception of meaning rather than the event itself [23].

Focus groups discussion capitalizes on the fact that members react to what is being said by others, thereby potentially leading to deeper expressions of opinion. The team utilized unstructured moderator interview guide, nonverbal observations, field notes and voice recording through a 3-hour focus group discussion.

For quality control checks we shared field notes from the interview to enrich the context. It was necessary to confirm responses against some previous answers where appropriate to detect inadmissible responses. The researcher maintained a follow-on dated reflexive journal in an effort to bracket: interests, things that I took for granted, clarifying personal values, possible conflicts or lack of neutrality, remaining open and looking out for surprises.

The phenomenological researcher asks: what is the essence of this phenomenon as experienced by these people and what does it mean? [11]. Focus groups discussion capitalizes on the fact that members react to what is being said by others, thereby potentially leading to deeper expressions of opinion

The study made use of purposive sampling all the nurse managers working in the hospital. Target population was a purposively selected, fairly homogeneous group of all the 16 nurse managers (13 took part in the mixed study a few weeks earlier), 6 subjects (2 males and 4 females) were conveniently selected for the focus group discussion while conveniently 2 (1male, 1female) in the face to face in-depth interview with seasoned nurse managers

Data gathering was done in 2012. The setting: A venue of choice which was a familiar meeting point that acted as a conference room within the working environment during tea time (10 am) ending at 1 pm. The arrangement was informal, some sitting on easy relaxing chairs or across a table. We employed the use of unstructured moderator interview guide, nonverbal observations, field notes and voice recording through a 3-hour focus group discussion.

The panel consisted of moderator/note taker I (a BSN staff nurse), note taker II (a monitoring & evaluation officer who was also an experienced transcriber), observer/ non-verbal (a nurse counsellor). Recording of voice was allowed. Probing was done up to exhaustive exploration and completion of data (saturation).

A recorded formal face-to-face interview with two seasoned nurse managers (one male, one female) was done in turns in one of their offices. Why? It became necessary to obtain varied views, confirm and enrich understanding on some themes that had emerged from the focus group. They were seasoned in the sense that they had mentored most of us who earlier on worked under them as staff nurses.

A shared view between participants and researcher added to the study's 'authenticity' and honesty. For rigor in the methodology member checks on site were allowed on voice recorded and summaries made with critical feedbacks although it added little to the accuracy of the transcript.

Transcription was also taken as part of the analysis process. Each transcript was systematically checked for verbatim accuracy by listening to the audiotape while reading the notes that were taken in free hand, working with a peer reviewer. Sensitive information was marked, anonymized or expunged from the transcribed format where necessary.

Some modified Colaizzi's procedural in phenomenological data analysis steps referred in [12] involved going back and forth on the protocols and returning to participants to validate some of the findings (see figure below). It allows participants/clients to be exposed to the ongoing research as it develops. Two

participants were asked to review the study findings, and both agreed that the results captured their experiences.

The analysis was done thematically and in verbatim where necessary supplemented using ATLAS. *ti 5.0 scientific software*: Meaningful segments were identified, categorized, coded and portions of the text corresponding were subsequently retrieved. The final results have been presented in 5 key points. Some findings were triangulated with the quantitative results to from the wider study [9]. These were subjected to secondary analysis 2 years later by the same researcher to unearth some more hidden meanings as seen in figure below.

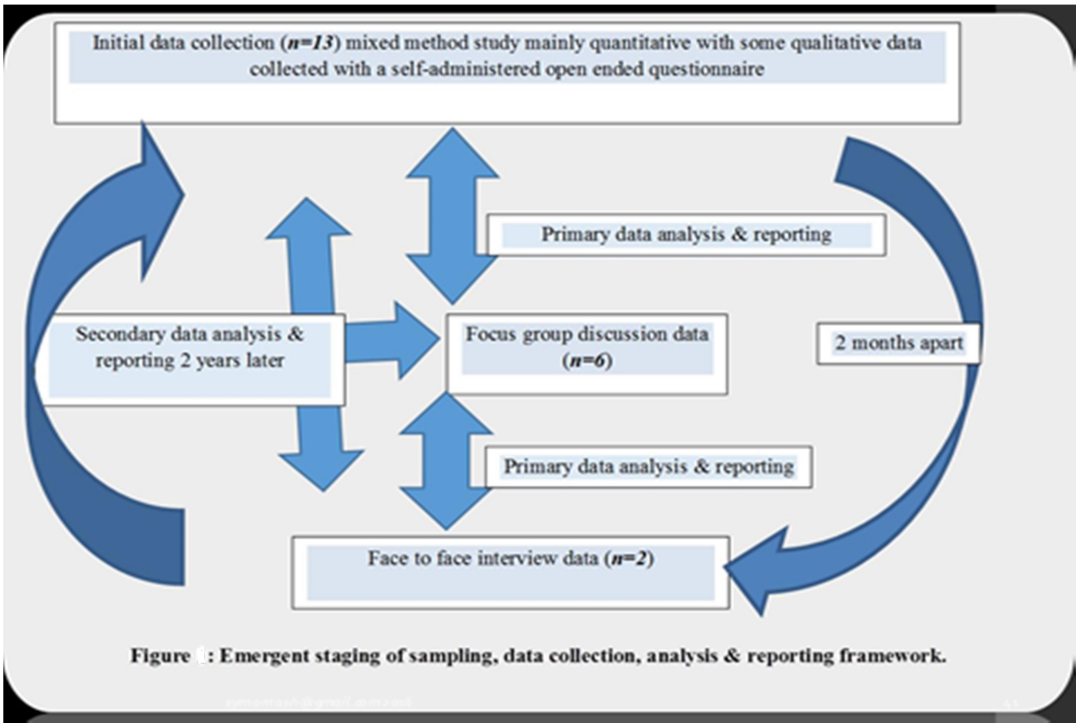


Figure : Emergent staging of sampling, data collection, analysis & reporting framework.

11.5.1 Data management Plan

To enable organization, durability and data sharing of this research; essential documentation

- about analyses or data manipulations, creating classifications for persons (e.g. interviewees), data sources (e.g. interviews) and coding was done. Classifications contained attributes such as the demographic characteristics of interviewees, pseudonyms used, and the date, time and place of interview.

Documentation files like the methodology description, conceptual framework, interview guidelines and consent form template were imported into the ATLAS *ti 5.0 scientific software* project file and stored in a 'documentation' folder in the Memos. All textual documentation in ATLAS *ti 5.0* was later exported either as textual files, a whole or groups of objects or summary extracts reports. As much as possible data was converted to standard, interchangeable and longer-lasting formats that hopefully most software would be capable of interpreting e.g. Rich Text Format (.rtf), Open Document format for textual and Free Lossless Audio Codec (FLAC) (.flac) for audio recordings. All with the necessary backups.

The study outcomes were shared through several avenues including (Macharia, 2012; Kamau, 2012; 2014) and repositories the University of Colorado http://hdl.handle.net/10217/78933 among others [29].

11.6 Delimitations

A potential limitation of peer research is the researcher's inability to be objective about group (or self) processes, which can result in unsuspected short-sightedness about important but sensitive issues. The Observer-as-participant in acting capacity was first described in the classic works of Goode and Hatt in mid-50's [13]. (Take help of tutorial on *YouTube*) https://youtu.be/ZAkrP9bFXzA.

The Observer-as-participant was used whereby the researcher participates in a one-time slot but then takes a back seat to any further activities but would un-obstructively take notes. This author found it necessary to recruit an independent moderator (a staff nurse) to steer the discussions in the focus group discussion. This prevented ‘‘leading" the discussion. This effort it was hoped would create a platform where the rest of my colleagues would discuss freely.

Prior to, during and after this discussion the researcher maintained a follow on dated reflexive journal in an effort to bracket: interests, things that I took for granted, clarifying personal values, possible conflicts or lack of neutrality, remaining open and looking out for surprises. Any biases as such were also overcome by employing qualitative and quantitative data collection methods at different times [9]. The entity of the study area as an employer to the respondents and researcher; meant that a few aspects of the study findings would only be covertly disclosed.

11.6 Ethical approval

Permission to expedite on the study was sought from the Institutional Research and Ethical Committee (IREC). Process consent was sought at each stage. The identifying features of the study site and subjects have been removed from this report, while most of the issues raised have since been addressed.

11.6 Results

Some of these findings were triangulated with the quantitative results from the wider study: The mean age of respondents was 40.9 years (38.9% of the nurses were between 31-40years) the rest were over 40 years with 70% being female. The majority were married (only 10% were single), 70% had a Bachelors of Science in Nursing (BSN) degree while the rest had both Higher Diploma and Diplomas. Duration of engagement in this hospital mean was 6.3 years and 9.3 years as nurses since graduating. All those who responded were confirmed as Nurse Managers and none was in acting capacity [9].

11.6 The Conceptual Framework

Final results have been presented as clusters and categories. These were described by Groenewold (2004) in illustrated phenomenological research design [20] and Leedy and Ormrod, (2001) in Stories rather than surveys

> The American Nurses Association ANA had come up with *7 Things You Should Know to Be An Effective Nurse Manager*
> http://lists.ana.org/img/lists/ana-leadership/16-207-ANA-roadmap080416%20FINAL.pdf.
>
> Some of the following concepts were incorporated in here:
> i) Know who your go-to people are;
> ii) Meet with your team to set clear goals, visions, objectives, and expectations;
> iii) Assess your team's strengths and weaknesses, along with areas for improvement;
> iv) Take time to get adjusted to daily changes, situations, and open conflicts;
> v) Maintaining composure and positivity for your staff is key;
> vi) Get to know all the processes, data, and procedures that impact your team;
> vii) Be a team player who is reliable and resourceful. Continued education and training help everyone stay on top of best practices.

The conceptual framework shown in figure below evolved as an emergent design reflecting on what was already learned [11] and not out of a prior theory. Therefore it captured the results as they came out. This will be discussed later on. The original conceptual framework on these underlying assumptions of the perceptions of nurse managers towards their roles in the hospital were first used in the inventory study on job descriptions of nurse managers [9].

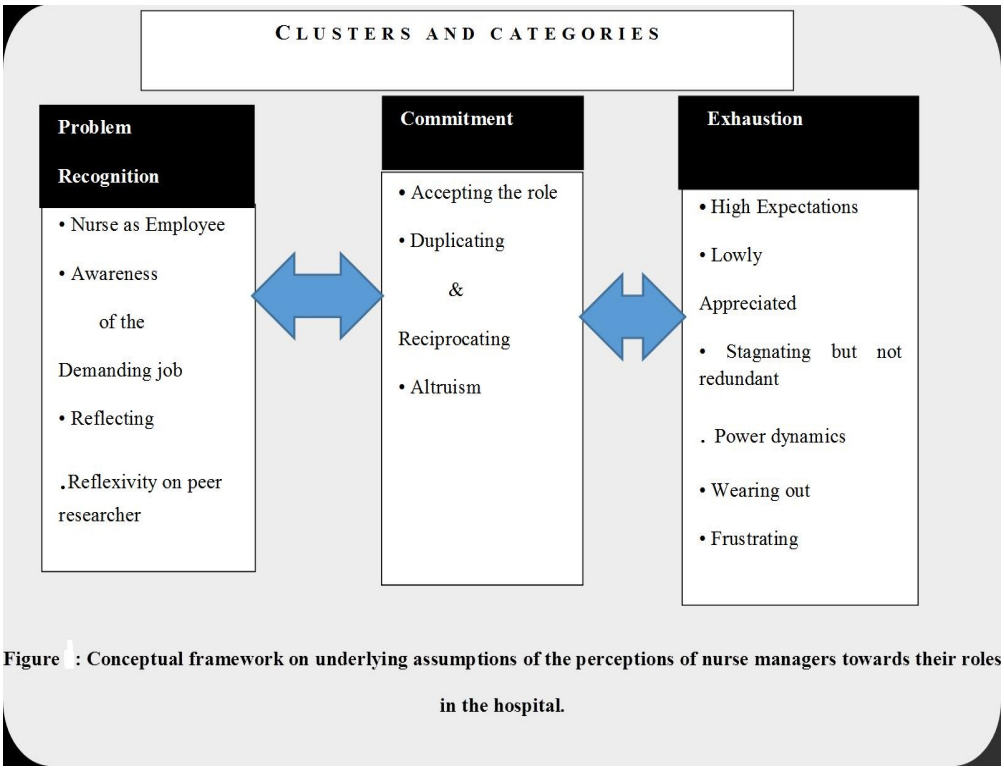


Figure : Conceptual framework on underlying assumptions of the perceptions of nurse managers towards their roles in the hospital.

(Used with permission: Kamau, S. M. (2014)

11.9.1 Themes

There were many common themes and reconstructed voices expressed across the focus groups and interviews emphasizing the need to elicit authentic self-expression of the interviewee [14]. These were observed when reviewing the data. A summary of the findings is given in 5 key points below: -

Key point 1. Challenges of the nurse manager position: - Was the position interesting or just plain challenging? - Mixed reaction responses: Representative quotes: 'I think given an opportunity to make some alterations; being a nurse manager is challenging rather than interesting. Challenging in the sense that there are a lot of responsibilities that are bestowed in a nurse manager especially now that we are moving in a direction where you can't recognize the roles of a nurse manager'.

'I think in a functional system, I could say it is interesting to certain extents. It appears that those responsibilities that others are shunning end up being handled by the nurse manager. So you spend most of your time addressing non-nursing duties'.

Interesting Position, representative quotes: 'Ok, I would say that it is actually interesting to be a nurse manager because considering the different situations that you will find yourself in and realising that you are able to advise, to supervise and even get through the challenges as my colleague is saying'.

'Getting through the challenges as he has mentioned, it is interesting. When you come on duty in the morning and at the end of the day reflect back on the aspects of services you have offered to the client, they are very varied and I think that is where the aspect of the job is interesting comes in.

So, despite all the challenges that the nurse manager goes through, at the end of the day, I would say that it is an interesting role'.

Challenging position: Representative Quotes - 'It is more of a challenge than interesting because the issues handled are quite many, things that you may find that some are outside the nursing duties, one goes out to do administrative and even some involving the engineering sections because some of these items we use involve engineering. Those under the nurse manager expect him or her to know some of the issues revolving around engineering'. 'I also agree that it is more of a challenge than an interesting thing, because if what my colleagues have said. We all carry the burden of almost everything in the hospital'.

'The greatest challenge as a nurse manager has to be when you lack what you are supposed to have, for example, equipment. You could be having maybe two O_2flow meters in a big unit. So you don't have the equipment required for the people on the ground to use, it becomes a very big challenge because they are supposed to work using this equipment and supplies, so that is a challenge'.

'Decision making on its own is challenging because being a player, you may make certain decisions that the management may not agree with. Such occurrences' affect the managers negatively'.

'My issue is recognition, when you are holding that title 'Nurse Manager', some people may not recognize you, as the office expects you to play a big role when the doctors consider you just another nurse'.

‘They have to come very early in the morning and the last people to leave in this hospital that is my observation'. ‘In supplies department, there are shortages of items, we get information, pass it to the relevant authorities and make orders, but the process takes quite some time for supplies to come, the authorities above derail the process yet all the blame goes the nurse manager. There should be a bridge to communicate between the management to provide these things in time. The blame on the nurse manager by the authorities above is wrong'.

The conclusion to Key point 1: Nurse managers tended to agree to disagree as to whether the job of the nurse manager was challenging or interesting. There appeared to be some apprehension about coping with challenges, perhaps they felt overwhelmed by some challenges and multiple roles. Sort of agreeing with Williams *et al.,* [30] who summarized it thus: As professionals, nurses are accountable for their own educational development, growth of their own practice, and execution of their own professional role.

As advocates, nurses provide direct and indirect care focused on the achievement of optimal health. As innovators, nurses act as agents of change in driving processes and policy and leveraging technology. As collaborative leaders, nurses lead within the professional practice setting with state-specific nurse practice acts, a defined scope of practice, and nurse-led initiatives.

Key point 2: Benefits that the position of a nurse manager offered (if any): What the nurse managers really felt about the benefits of this position: Representative quotes: ‘I don’t think there are any added benefits to this particular position apart from the fact that you attend meetings at some level otherwise no added benefits’.

‘Job satisfaction working as a nurse manager, when your unit is running well and challenges that were there are addressed. By the end of the day, you have that satisfaction'.

‘So job satisfaction and self-motivation are the benefits considering that you could be earning less than the others. I am saying this because you might have some nurse managers who are at lower levels than their subordinate.’

Key point 3: Nurse Manager: - The Roles versus the Job: The nurse managers strongly believed that duplication of roles existed in the then work setup.

Representative quotes: ‘As a nurse manager, I don't think that there should be duplication of roles in the unit. For example, client who has been given a bill which is erroneous and the person has a complaint, he/she will be told to go and see the nurse manager. As you try to go through that, you realize that you will be getting a challenge because of someone else's mistake but once the patient complains, they look up to the office of the nurse manager to solve such issues. It's a give and takes'.

‘It comes down to what we have said earlier that the position of a nurse manager carries lots of responsibilities carried from elsewhere, since you seem to understand the needs of a client, you tend to go an extra mile to make sure that certain requirements are supplied. At the end of the day, you would have worked so hard and felt tired'.

Key point 4: There perception on what makes a good/outstanding nurse - Who an outstanding nurse was to the nurse managers: - The nurse managers thought basic but appropriate nursing knowledge and reasonable communication skills as traits that should be portrayed by an outstanding nurse

Representative quotes: 'I think it is that nurse who has knowledge about nursing and responds complete to nursing needs of the client. Responses which are appropriate based on the required knowledge'.

'If I can add to that, should be a nurse that is able to provide quality services to patients which entail prompt services to the patient, being able to report on the patient, s/he should be adequate in terms of documentation-so that everything was done is able to be reported'.

'Should be a person who is able to communicate with the patient, for everything that is done to the patient one should be able to get back and explain to the patient and let the patient understand and participate in terms of care'

Key point 5: There Perception on what should be the requirements for a nurse manager position. Special abilities that a nurse manager should have

Representative quotes: 'I would say that a nurse manager should have very many special abilities which I don't know whether it is possible to mention'.

'One thing, as a nurse manager you need to have very good human relations skills that are communication and interpersonal relationship, because as we have heard, you deal with a varied number of people from nurses to engineers, so you have to have the ability to communicate very well with this people for things to run.

At the same time, there is need for technical skills in nursing because when you supervise as a nurse manager you have to have the highest attainable skills for whatever area you are dealing with because you will be supervising the students, supervising the new nurses, even these other nurses. So it is really necessary that you have the highest skills as far as the technical doing of whatever is required. At the same time, the issue of organization, a nurse manager has to have good organization skills because as we have said, your day has so many activities and to all these activities you really need to know how to organize them'.

´They have to have very high levels of decision making because they will be meeting with so many things that need immediate interventions. So as a nurse manager you have to have very high skills in decision making, so as to prioritize, so as to have whatever is to be done should be done carefully because it is something to do with the life of a patient'.

'Maybe I can add the issue of being observant so that you are able to capture all the things that are happening to the unit, whether it is problems or staff that are coming on time and those not coming on time, you know? Really having that extra eye'

'I also think that networking is a very important aspect here because as a nurse manager you are an actor between the people who require the service, management and those who provide resources. So for you to be able to adequately address the problems, you need to know the functions of relevant department in the hospital so

that you can link this others pieces together'.

‘Education – degree or a doctorate , whatever it may be , but it should be utmost high’ ‘It should not be separated at the highest level and the practicability of the work, they should be considered in all spheres, the highest level attainable and also very practical best performing ‘coz you could have the papers but you are not performing, so it should actually be the highest level as possible but also be a very good performer regarding the issues to be handled' ‘Education and practice should also be the case'.

‘Most of the time I see people being appointed because they are at N1s level’. (N1= designation nursing officer grade 1 conventional acronym is NO1).

‘At times, it is possible to have somebody who has attained the highest but attitude may end up affecting the behavior of how somebody approaches responsibilities'. Other issues that might be important in appointing nurse manager

Representative quotes: ‘I think experience is something that should be considered so that to be appointed to manager at a particular place then you should have had experience in that field for quite some time'.

‘Concurring with what Number three is saying you should have at least rotated in all divisions. In the event that one is appointed in one division, the manager can be able to work well when there is changeover of staff. We also need to be gender sensitive, we have to mix females and males in different areas, so that when they have meetings they can interact and at least share ideas'.

‘I tend to differ a bit in that, if you have the qualities of a nurse manager, as we have mentioned earlier, you can even be appointed as a nurse manager in a place you have not worked because basically, you have the general training and everything, you also have the good skills we have talked about, communication, decision making, organisation. So I think you can still be effective even in a totally new place which you have not worked provided you have the basic requirements as we have said'.

‘Secondly, regarding the issue of gender, it is good to be in line with the other national policies on gender but at the same time that should not be the only reason; you should not be appointed because you are not common. Maybe they are not common for example; all the nurse managers might be women and so you want to bring a man, bring him because of the qualities. Gender should go hand in hand with the requirements. The position should not just be given out based on gender’.

What the nurse managers perceived as the next steps that would improve the position and improve output:

- Nurse Managers felt the need for the hospital management to review their remuneration and give substantive allowances and some sort of recognition.

- Nurse Managers felt that there was the great need to restructure the position. They felt that once the position was held for some time, preferably 2-3 years,
one should be allowed to move to other exciting positions for growth without

being viewed by the management in a bad light.

- More results could be realized if nurse managers oversaw operations that were related to their particular nursing fields. This would not only ease operations but would also facilitate the spirit of ownership and job satisfaction.

- Nurse Managers need to be capacity built with much emphasis laid on leadership, administration and public relation issues. This would ensure that a nurse manager would be capable of handling the roles assigned to him or her and at the same time being able to correctly report and share with the rest of the hospital.

- Duplication of roles needed to be AVOIDED.

- Despite the fact that they did not have substantive allowances or recognition from other players in the hospital like doctors do, MOST of the nurse managers felt that they had experienced personal growth.

- There was a heated debate about the general progression and advancement of nurse managers. ALL the participants felt that the hospital management needed to come up with reasonable and clear criteria for progression and advancement for the position of the nurse manager. Suggestions for advancement included setting up intermediate positions between nurse managers and the hospital's Chief Nurse. They felt that creating such positions should be informed by the need, and would strengthen their progression.

11.9.2 Surprises

The biggest surprise that came out of the study was the fact that the nurse managers held the opinion that, the Title NURSE MANAGER in then setup of the hospital was a nothing but a vague title. This attributed to the fact that they saw no end after being in this position. They strongly felt that there was need to re- structure the position. 'It is sad to say this but I think the hospital has used as a way of obtaining cheap labour. A way of getting maximum output with minimum labour' one participant said this indignantly.

The second big surprise that came out of the study was the fact that the participants held varied opinions on how the nurse manager should hired- some felt that the position should be advertised and make it competitive while others thought appointments should be made.

'This position would be more appropriate for it to be advertised so that those who have the interest can apply and that the appointing authority can have an opportunity to vet those who have applied when it comes to skills and experience we have discussed.'

'I think the process of appointment is better, considering this is an appointment that is happening after ones performance has been observed over time. Unlike if it was an advertisement because anybody else can apply. So how can we then verify this person who has come for an interview that s/he is effective as a nurse manager? I don't mind the appointment considering that they are appointing you after observation'.

Summary on the Roles of a Nurse Manager

The participants reiterated that the following broad roles should be the core duties of a nurse manager: To oversee patient care and ward/Unit management. Responsible for hospital linkages between the other nursing personnel and other sections (including the hospital management) to oversee educational and supervision functions. Other administrative and personnel disciplinary functions strongly related to their jobs [25]. Core abilities necessary for nurses in administrative roles include:

- Abilities to use management skills that enhance collaborative relationships and team-based learning to advocate for patients and community partners
- To embrace change and innovation
- To manage resources effectively
- To negotiate and resolve conflict
- To communicate effectively using information technology

11.9. 4 Discussion and Conclusion

As seen in figure above the findings could be allocated to the following clusters and categories:

Problem Recognition: Nurse as the employee- must support system, awareness of the demanding job, reflection on the part of the participants with sudden grasp of meanings vividly brought out. Some respondents disagreed that the job was satisfying to them. Some apprehension was obvious. Reflexivity (self-scrutiny) on the part of the peer researcher, a nurse manager himself.

Commitment: Accepting the role, altruism, duplicating and reciprocating. All respondents agreed that they did work that someone else was supposed to do.

Exhaustion: High expectations- getting less than needed support, lowly appreciated, stagnating but not redundant, wearing out, frustrations- some quite intense, power dynamics (inter and extraneous) between nurse-cadres and up against other health care disciplines. Lack of recognition, supplies, and equipment came out strongly as limiting factors in the performance of their complex roles. They felt generally overworked and not paid in commensurate.

These findings agreed with [15] who a studied a wider scope of nurses in the Rift Valley Province and also with [16; 27] case study of Kenya on Human Resources in Nursing (CHRIN) to International Council of Nurses. Both recommended that a number of studies needed to be carried out to shed more light on some critical areas in human resource dynamics in nursing and further that remuneration for health workers needed to be improved further to facilitate retention of nurses in the country.

There was great need to clearly outline the nurse managers' role in the hospital as their job description. Their roles were either complex, multidimensional or both. There was need to equip the nurse managers with leadership skills tended to agree with: International Council of Nurses (ICN) and Canadian Nurses Association (2005)

position statements and American Organization of Nurse Executives (AONE, 2004) that The best way to organize the delivery of care was still a dilemma, there would be increasing demand for healthcare services and with increasing acuity; The work environment domain recognized that: -Rigid structures that lack the capacity to be flexible and innovative stifle the work environment and discourage nurses who see ample opportunities to improve care processes.

Insightful view

Presenting an insightful view of the findings was described by Morse (2006), "and then I had an idea." While [18] 'using metaphors and changing words to represent things as they are through altering the … perception …of, 'data' as isolated bits of fact…'

No better way to tie all these together than the metaphor [22] scripted and shared by one of the two seasoned nurse managers during a follow-up interview which summarized contextual factors surrounding the respondents went like this;

> *'In Africa, we attempt to explain phenomena using analogies. A giraffe is one of the main attractions in sub-Saharan Africa. An elegant, stately animal. You should see it towering the heights of the Savannah, chewing very tiny leaves from among the acacia thorns. But you have not seen anything yet! Wait until it takes to run, what a wonder.*
>
> *When it bends to drink from a pond, it looks so vulnerable. It appears to be something to do with its supporting structures or more likely the system it has to support. So is the nurse manager in the developing countries like Kenya'.*



Pic: The giraffe [Acknowledged metaphor scripted and shared by one of the two seasoned nurse managers during a follow-up interview. Photo courtesy of Encarta].

When requested to describe this more fully, it came out that the nurse manager, just like the giraffe is an indomitable figure in any health care setting. He/she bears the image of the hospital, going to great lengths/heights to ensure the smooth running of the institution amidst daunting challenges of a changing work environment. There seems to be an apparent disharmony between the supporting structures available for him/her most of the time as well as the health system she supports.

Apparently, this offered an insightful view of the findings. Morse a prominent nurse researcher posits qualitative researchers to be ready for insight and that they must have considerable knowledge about their data to be able to link them meaningfully[17].

Being a single site study of a small convenience sample, it may be risky to generalize the findings without replicating the study with another sample in other contexts. Perhaps some of the limitations mentioned in this study could be overcome by having organization(s) commission such studies through task forces as this may bring out salient issues. But then day-to-day management in an environment of resource constraints and uncertainty requires in-charges who were resilient, reflective, and continuously able to learn and adapt [31]. The study was done in 2012-2013, the immediate period after devolution of health services in Kenya highlighted the importance of leadership development including the building of critical soft skills such as relationship building. Health facility staff can be impacted upon by health sector reforms in unintended and sometimes damaging ways, it was hoped that decentralization would be able to achieve these.

11. 9. 5 Utilizing Abraham Maslow's theory of motivation to explain the phenomena

Maslow in 1943 posited that human needs are organized into a hierarchy of relative potency. Maslow uses the terms like esteem needs to describe the general stages that human motivations move through.

- According to Maslow's theory, every human being has basic needs. People are motivated by the desire to satisfy these needs. As one need is satisfied, another appears and takes its place, and the individual is then motivated to satisfy the new need.
- Inherently, one cannot achieve self-actualization or self-drive unless all the lower level needs have been met.
- Self-actualization is the ultimate drive or motivation that comes from within an individual. It is an indicator of self-growth
- In regards to Maslow's theory, prestige is a factor of esteem; without it, one has lower esteem, and without esteem, one cannot achieve self-actualization. Today self-actualization has another level above it - self-transcendence that is as you actualize and even touch the lives of other people.
- A holistic, human and personal approach to the needs.
- Includes observations about people's innate curiosity and not just what

motivates them.

- Many nurses have used Maslow's theory of motivation and hierarchy of needs as a framework for planning patient care.
- Since Maslow's needs apply to all human beings the theory can be extended to nursing management as well. In this case, it will be employed in the investigation of the levels of motivation among nurse managers.
- The study revealed that most of the nurse managers in the study area in western Kenya were not enthusiastic as nurse managers as they saw it as a mere title.
- It seemed that nurse managers could certainly reach their social needs but would have difficult time succeeding with Esteem and Self-Actualization needs to give the constructs of the job. It has been ascertained that employees who had high levels of self-esteem, a positive self-concept were more productive.
- A new entry into the hierarchy Self-transcendence is said to supersede self-actualization is an area nurse managers have made some breakthrough as they touch the lives of others in caring.
- Individuals at work experience a variety of needs. Managers and/or supervisors should identify ways in which to meet group or individual needs to motivate them to work.

Please see the schema Maslow's theory of motivation to explain the phenomena *levels of motivation among nurse managers* below:

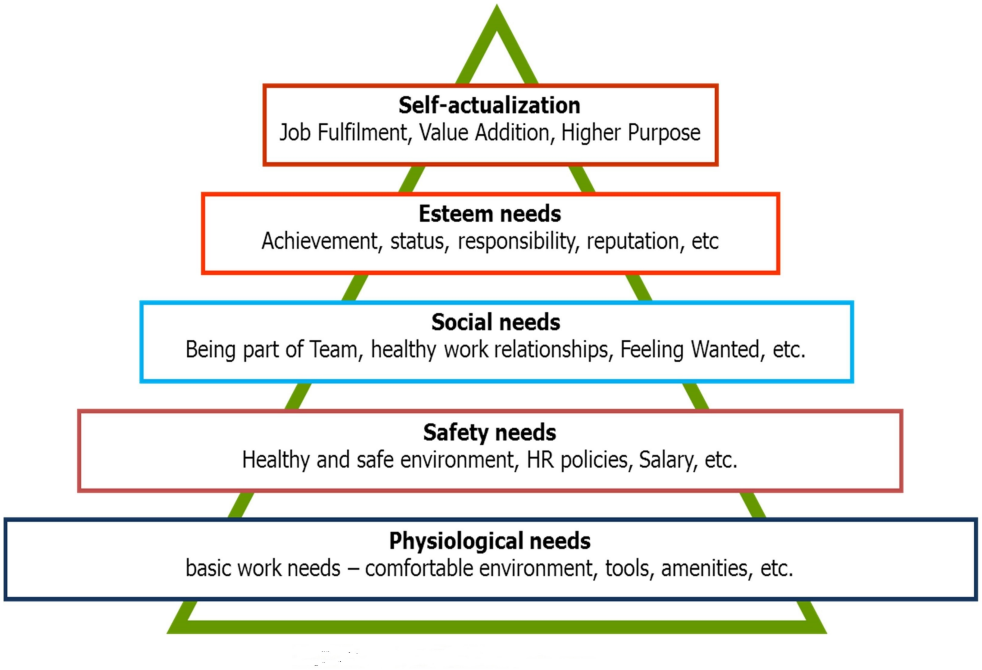


Fig: Maslow's theory of motivation to explain the phenomena levels of motivation

Levels of motivation among nurse managers (Modified from Vipin Ramdas, 2016)

http:// www.vipinramdas.com/maslowshierarchy/

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This work was modified from a course work project [MSN Leadership & Health System Administration, University of Colorado Denver]. Part of the report appeared in Kamau, (2014). Used with permission.

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CHAPTER 12

Utilizing Theory and Evidence to Deliver Care IV

Management of Self and Accidental Poisoning in a Low Resource Health Care Setting in Western Kenya

Chapter co-authors: Simon Macharia Kamau, Alex Kipbichii Chebor, Henry Ruiru Mwangi

Overview

Poisoning due to pesticides is an important cause of morbidity and mortality worldwide. About three million cases of poisoning occur worldwide annually, mostly in developing countries with Organophosphates poisoning (OPP) being seen more commonly compared to others. With more than 200, 000 deaths each year in developing countries.

The study setting was Intensive Care Unit (ICU) of Moi Teaching and Referral Hospital (MTRH), a public referral hospital serving North Rift and Western Kenya. Sampled were patients admitted to ICU due to poisoning, between 2006 and 2010, both years included. Objectives were to determine the number of poisoning cases in the critical care setting, clinical interventions given and establish the patients' management outcomes among these patients at MTRH.

The study adopted a retrospective records and charts review, whereby poisoning cases possibly due to carbamates, amitraz and organophosphate were reviewed. Cases were identified through the use of Intensive Care Unit admission register and forwarded to the department of health records f or retrieval of the case files. Data was collected by the researchers themselves by use of a predesigned patient records review checklist and charts review. Van den Eynden et al., (2011) describe certain aspects of how such data management could be done.

Results showed that the ages ranged from 1 year to 63 years old patients with a mean of 25 +14.8years. The male to female ratio was 1.5:1. During the study period, there was a total of 1063 ICU admissions of whom 85 were poisoning cases. Categorizations of poisoning for purposes of diagnosis or management as organophosphate, amitraz or any other was rarely done hence all were usually treated as 'organophosphate poisoning (OPP)'.

Atropine injection and mechanical ventilation remained the mainstay treatment of these poisoning cases. The mortality rate due to poisoning in ICU was 10.4% and none died in the wards after being discharged from the ICU. Whether or not PAM was used did not seem to make a significant difference. Though management of these cases was found to be inadequate due to lack of protocols, clinical judgment, some essential drugs and equipment it still yielded some positive outcomes.

12.1 Background

Acute organic insecticide poisoning is a major health problem all over the world, where organophosphates (OPs) are the most common suicidal poisons with high morbidity and mortality and account for a large proportion of patients admitted to intensive care units. Atropine has been the primary drug used to treat symptomatic cases involving both organophosphate and carbamate insecticides but remains controversial in managing amitraz cases though it is still used as the primary drug (Exner& Ayala, 2009). According to Eddleston (2008), the pathophysiology of organophosphates pesticide self-poisoning is not so simple.

Clinicians faced several challenges with organophosphates pesticide self-poisoning, for example, the speed of action of the pesticide ingested will determine if a patient will survive to make it to hospital after ingesting a substantive dose of poison. No general rules seem to be available concerning the solvents used for organophosphate pesticides. The same pesticide might be dissolved differently by different manufacturers in the same locality. Yet the solvents themselves could be responsible for early deaths especially the loss of consciousness. Loss of consciousness from whatever cause basically can lead to aspiration. Aspiration is a leading cause of death in organophosphate poisoning casualties.

Recommendations to use pralidoxime in patients with similar symptoms caused by a carbamate insecticide were much less clear (Cherian, Roshini and Peter et al, 2005).The benefit of pralidoxime use to manage nicotinic effects of the poisoning by OPP, Amitraz, and carbamates was said to be somehow beneficial. Amid these controversies, differentiating carbamate from organophosphates based on clinical presentation is often difficult because of the similarity of symptoms but treatment decisions must often precede analytical or historical confirmation.



Pic: Ingested poisons. Picture courtesy of *The Big Picture*

Owing to these controversies we sought to review cases admitted in Moi Teaching & Referral Hospital, Intensive Care Unit with a view of determining the management aspect and outcome of poisoning in our resource-limited setting then. Daren and Cynthia (2007) did an evidence-based review of the management of acute organ phosphorus

pesticide poisoning. They observed that household and agricultural products containing organophosphorus pesticides were prevalent, allowing many opportunities for acute poisoning. They thought there was a correlation between intent, dose, and severity of toxicity after acute poisoning and that each exposure required a thorough review.

12.2 Objectives

1. To determine the number of poisoning cases in the critical care setting during the study period 2006-2010.

2. To determine clinical interventions given to patients with poisoning.

3. To establish the patient's management outcomes.

12.3 Material and Methods

This was a descriptive audit study design. The study was carried out at Moi Teaching and Referral Hospital (MTRH), the second largest referral hospital in Kenya that serves Western and north rift Kenya with an estimated population of 15million(KDHS, 2003). Poisoning cases mainly due to organophosphate, amitraz, and carbamates admitted to Intensive Care Unit (six- bed capacity) during the four years study period (between 2006 and 2010, both years included) were reviewed. The list of these cases was made through the use of Intensive Care Unit admission register and forwarded to the department of health records for retrieval of the case files.

The sample size was limited to the number of ICU admission due to poisoning that met inclusion criteria. Data was collected between April 2011 and February 2012 by the researchers themselves by use of a predesigned patient records review checklist and charts review. The extracted data was assessed for completeness before coding and transfer into a computer for analysis using Statistical Package for Social Sciences (SPSS) version 19.0.

The primary outcome measure was mortality rate. Gathered data were analyzed in line with objectives. Proportion, measures of central tendencies and spread were reported for descriptive statistics. Inferential statistics assumed a 95% confidence interval and a test significance value at ≤ 0.05. Ethical consideration was upheld at all stages of the study.

12.4 Results

During the study period, there were 1063 patients were admitted in ICU out of whom 85 (8%)were poisoning cases. These cases were identified in the ICU admission register, but the analysis was based on 48 cases. This low figure of the sample size was due to irretrievability of case files from the records department and fairly incomplete documentation.

The ages ranged from 1 year to 63 years old patients with a mean of 25 +14.8years. The male to female ratio was 1.5:1.0. The county of residence (formerly referred to as district) for most poisoning cases was UasinGishu (45.8%) where MTRH is situated, followed by Keiyo a referring county (31.3%).The occupation of most patients was farming (35.3%).

The majority (73.9%) of the cases were suicidal attempts compared to accidentals (26.1%). On average the accidental cases were significantly younger (12+14years) than suicidal attempts cases (30+12years) ($p<0.001$) (see Figure below). Though the type of exposure was not associated with gender ($p>0.05$).Triatix® was the most (76.5%) taken poison, followed by Diazinon (17.1%) while 17.1% of the cases the poison was not known. The majority (93.8%) took the poison orally and only a few 6.3% were through parenteral route. Types of the poisons taken may reflect the occupation of the residents (see Table 1 below).

Most 32(66.7%) of the patients' admitted were Unconscious, 15(31.3%) had respiratory distress while 11(22.9%) had fasciculation (see table 2 below). On another hand 65.1% of the patients had miosis and 32.6% had mydriasis only 2.3% of the patients had normal pupillary size.

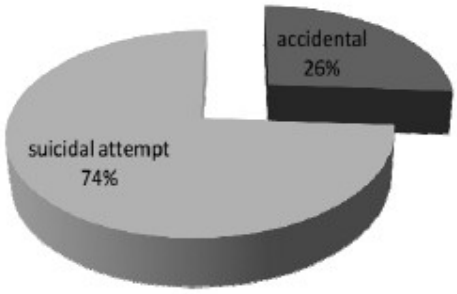


Figure: Type of Exposure

Glasgow coma scale rating of the nervous system ranged from 3/15 to 15/15 with an average of5.9+3.8 [N 15/15]. GCS of less than 8/15 was considered severe needing intubation and respiratory support. The patients took on average 33.97+0.6 hours to recover from CNS depression (minimum1hour to maximum 420 hours). 76.6% of the cases had hypothermia episode during hospitalization. The temperatures ranged from 32ºC to 41ºC with a mean of 35.5+1.5ºC [Normal range 36 to 38ºC]

Categorizations of poisoning for purposes of diagnosis for management as organophosphates, amitraz or any other was rarely done, all were usually treated as 'organophosphate poisoning (OPP)'.Inj. Atropine was routinely done at varying dosages of 0.2mg, 0.3mg, 0.5mg, 0.6mg, and 0.8mg in one case. 1to 2mg in 25.5% of the cases, 3mg to 4.3% of the cases, and 4mg to 12.8% of the cases.

Table: Demographic Characteristics of the Cases (n=48)

Variables		Frequency	Percent (%)
Gender	Male	29	60.4
	Female	19	39.6
Education Level	None	1	7.1
	Primary	8	57.1
	Secondary	3	21.4
	Tertiary	2	14.3
Occupation	Farmer	12	35.3
	Student	7	20.6
	Housewife	6	17.6
	Business	9	26.3
District of Residence	Uasin Gishu	22	43.8
	Keiyo	15	31.3
	Nandi	3	6.3
	Others	8	16.8

Inj.atropine was administered on a range of 1day to 14 days with a mean of +3days. Inj. pralidoxime (PAM) was given to 17patients, on several occasions during the study period it was reported as out of stock. The patients also regularly received inj. Zantac (67.6%) and inj. Dormicum (44.1%). The commonly administered antibiotic was inj. Ceftriaxone (26.5%). Majority (79.2%) of patient's required mechanical ventilation and on average took 3.2+2.6 days on mechanical ventilator.

The average length of stay in ICU was 4.17days for suicidal and 4.35 days for accidental, the difference was not significant (p=0.85). On average each patient paid Kshs 34,073 for hospital treatment with a range from Kshs 3,672(USD 41) to 158,592(USD 1781) over the years.

ICU mortality was 10.4% (see Figure below). All the patients who succumbed to the poisoning were suicidal poisoning cases while none of the accidental poisoning cases died. All (100%) those who were transferred out of ICU to the wards were eventually discharged home alive.

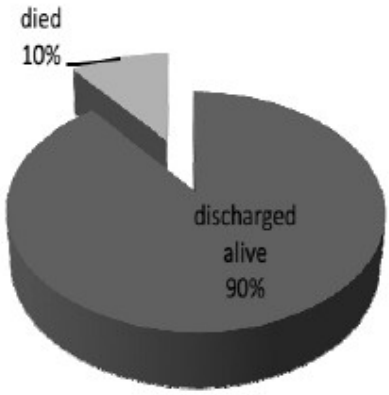


Figure: ICU Treatment outcome

Table: Complaints on Admission

	Responses	Percent Of Cases
Unconscious	32	66.7%
Respiratory Distress	15	31.3%
Fasciculation	11	22.9%
Drowsiness	5	10.4%
Hypersalivation	5	10.4%
Vomiting	4	8.3%
Diarrhoea	3	6.3%
Lacrimation	3	6.3%
Dizziness	2	4.2%
Disorientation	2	4.2%
Abdominal Pains	1	2.1%

12.5 Discussion

The ages ranged from 1 year to 63 years old patients with a mean of 25 +14.8years (see Table 1 above). The male to female ratio was 1.5:1. The overall case fatality rate was 10% all from deliberate poisoning, high in males (13.8%) than in females (5.3%) though this difference was not significant at 95% confidence level. These results showed similar findings with a study in Zimbabwe by Tagwireyi et al., (2006).

A study was done in Bolivia by Ayala (2009) similar findings in age composition of the patients but in their study found male to female ratio of 1:2 contrary to our

findings of 1.5:1. Sahinet al., (2003) also did a social-demographic survey and found out that OPPs especially affected young unmarried females, and most of them were due to attempted suicide.

The best way for treating poisoned patients is not yet clear. Injection atropine administration continued to be the mainstay of treatment in this study area; this was also supported by the literature reviewed by Tsai et al., (2007), Murat, and Muhammed (2001). This did not mean that use of atropine too was not contentious.

In this study centre, the irregular stocks of injection pralidoxime may not have had significant difference in the outcomes; this agreed with many other studies reviewed Tsai, et al., (2007), Murat and Muhammed (2001). Whether to use or not to use Inj. pralidoxime (PAM) was less clear both from literature and from our study area, in any case, it is clear that aged acetylcholinesterase cannot be reactivated by oximes (Eddleston, 2008). If at all it has to be of any benefit it must be given very early (patient presenting in 2 -3 hours) or in specific cases like in parathion poisoning be given in high doses for a long time. However WHO's guideline to give oximes to all patients and to continue them until atropine is no longer required.

The mortality rate of OP poisoning is generally thought to be high: fatality is often related to a delay in diagnosis or an improper management. In this study, it took patients on average 498 minutes to arrive at the hospital (MTRH) with a range of 45minutes to 1560minutes. Time taken to arrive at the hospital did not appear to be associated with the type of exposure ($p>0.05$).

Amitraz seemed to have better outcomes when its definitive diagnosis was made according to some studies. Damirelet al.,(2006) even concluded that prognosis of amitraz intoxications through oral route was benign and results in incomplete healing; however, we suggest that these cases should be well monitored and followed-up in ICUs. In our audit, there was rarely that definitive diagnosis, this could have been related to inconclusive history and lack of protocols.

Documentation in our study centre was fairly unreliable that so many cases had to be dropped from the study. Retrospective studies depend almost entirely on proper documentation. This posed a significant limitation in our resource-limited setting.

12.6 Conclusion

- Poisoning continued to be a challenge in the local critical care setting in over the years.
- Preparedness before and during the audit on management of these cases was found to be inadequate in terms of life support equipment and drugs. No protocols were in place.
- There was inadequate information available (from the retrospective records analyzed).
- Guidelines (if at all used) given on individual clinician's preference were based on knowing the ingested pesticide (or its solvent for that matter) and this was something that was not always certain even when the pesticide bottle was brought.

· Not possible to know about the specific poison that was involved, there seemed to be a general assumption that all such poisoning presenting in the unit were caused by organophosphates and were managed as such.

· Injection Atropine administration continued to be the mainstay of treatment. Whether to use or not to use Inj. pralidoxime (PAM) was less clear in the study and in any case, it was irregularly stocked.

Ⓨ Almost all the patients required life support facilities like mechanical ventilation.

12.7 Implications

Though management of these cases was found to be inadequate due to lack of essential drugs and equipment, protocols and at times less than proper clinical judgment, it still yielded some positive outcomes. However, where management was based on good clinical judgment there were positive outcomes inspite of other shortcomings.

These could have been better if the referral facility was well prepared and equipped to handle these deserving patients.

Patients with moderate to severe organ phosphorus pesticide poisoning usually require management in an intensive care unit. Darren and Aroon (2007) evidence-based review organophosphorus poisoning was able to establish this as a fact. There is, therefore, need to have at the earliest opportunity an ICU to be set up in all level 4 and 5 county hospitals in Kenya.

For resource limited settings this audit has shown that it is still possible to offer some basic management of poisonings like immediate resuscitation, decontamination, and life support even without a definitive diagnosis. However, these need to be done to a certain point by all referring facilities.

12.8 Recommendations

ⓎMarket forces dictate that fast acting, highly toxic, pesticides will continue to be used in agricultural practice. Finding a way that less toxic substances could be used within the farming community could mitigate the effects of self and accidental poisoning. Solvents might be causing more toxic effects than the pesticide, if they were, it would be valuable to identify a number of safer solvents for pesticide manufacturers.

ⓎThere is need to introduction of forums to address the psycho-social problems affecting the community served by the MTRH to mitigate the menace.

ⓎThe space available for ICU admissions was very constrained thus it would be necessary upgrade catchment referring institutions to be able to manage poisoning cases.

There was an urgent need to put in place protocols and regularly update them based on evidence. Utilize national as well as regional poison hotline centres and algorithms by the health facilities as well as the community.

- Need to allocate more resources for life support (e.g. mechanical ventilators, infusion/syringe pumps) to ensure 'best care anywhere' in western and north rift regions of Kenya.

- As a general observation, making available larger volume ampoules or vials of inj. atropine sulphate injection and syringe pumps for continuous bolus would ease on nursing time of breaking x50 of 1mg glass ampoules per patient.

Acknowledgement

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CHAPTER 13

Utilizing Theory and Evidence to Deliver Care V:
Addressing Nurses' Workload by Utilizing Research Brief - Annotated Bibliography

Overview

This chapter is a modification from a much briefer document by the same title that was sent by this author to the concerned stakeholders from two capstone sites in Zendi County (fictitious name). Workload according to *Human Resources Norms and Standards, 2014* considered three factors: the effort (i.e., time) required for specific health staff to carry out particular activities; the category allowance factor, which is additional time spent on non-service activities (e.g., management or record keeping); and individual allowance factor, which is time spent on activities by specific individuals in a staff grouping (e.g., a matron's additional activities above other nursing staff).

It provided guidance on the levels and skills of health workers needed to deliver the Kenya Essential Package for Health (KEPH). These norms and standards were developed through the Workload Indicator of Staffing Needs (WISN) approach, an evidence-based method that considered the work actually performed by staff at a facility. Staffing norms and standards are usually – population based; facility based; disease pattern based. Acuity was a special consideration among other circumstances. Acuity in terms of severity, crisis of an illness.

More work, faster, with less, is hard for anybody and nursing is no exception. There is a direct relationship between nurse staffing and patient well-being. Nurses serve as an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing RN staffing.

High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers. This was according to Human Resource for Health (HRH) 2009-2012. In human resource, management-staffing is the process through which an organization ensures that it always has the proper number of employees, with appropriate skills, in the right jobs at the right time to achieve organization's objectives.

The erosion of Kenya's key health indicators – life expectancy, infant mortality and maternal mortality – during the last two decades can be traced at least in part to the deterioration of the health work force. The acute shortage, inequitable distribution and inadequate skills of health workers have contributed to this negative trend. Staff shortages

are particularly acute in hard-to-reach regions. Staff shortage will likely become more severe before it gets better. Annexed to this Chapter is a policy brief to The Cabinet Secretary, Ministry of Health, Kenya & Chairman, Council of Governors Kenya, entitled *The Nursing Situation in Kenya: Patients Deserve Better Care* (also see **Policy Issue** in Chapter 2 & and **All alone** in Chapter 13).

Nursing is important in quality and safety of hospital care and in patients' perceptions of their care. There seems to be a close association between patient's safety, undergraduate nursing students' learning with nurse staffing levels in Kenya. The Ministry of Health, as well as the Ministry of Education, do not yet support changing nurse workforce standards for teaching medical institutions.

This research brief targeted sites were Kijani Level 4 and Zendi level 5 Hospitals (not their real names), both acting as teaching hospitals for School of Health Sciences, the University of Kue (not its real name), Kenya. The review focuses on nursing staffing as an issue, and the effect of workload on patient outcomes, students, and staff outcomes. Hospitals were going to be paid for good patient outcomes (value) and not paid for services related to bad outcomes derived from the processes of care (e.g. Hospital Acquired Conditions). This was already happening elsewhere hence need to transition from volume to value. This called for among others improvement in care coordination and quality of care while decreasing costs.

Given that nursing is the largest provider class in hospitals, the potential for nurses to improve outcomes is limitless. This brief sought to some extent establishes the relationship between nurse workload and nurse-sensitive patient safety and students' learning outcome indicators existing in research.

Scheduling around workload is now a critical method of staffing, so is contracting float/pool nursing for workload - bringing staff members on board based on an agreed workload and paying them for the workload rather than based on metrics of time. These methods give staff more control over their work-life and life outside of work. This has become a reality in some of the big towns in Kenya with some nurses by design or by choice remain without a permanent job for extended periods of doing 'locums'.

A search mode was developed. The online search spanned a period of between 2003 and 2014. A research brief and annotated bibliography were compiled from the relevant literature. The research brief is designed for the nurse manager and policymaker to provide information without requiring extensive reading. The reader can choose to dwell on the specific section(s), to start anywhere in the main text, or just the annotated bibliography.

There were a lot of staffing issues in research that could be applied in the two teaching hospitals. Kenyan nurses and nursing faculty might be interested in a staff-understandable review of what has been researched. Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis.

A fair and balanced patient assignment increases nurse satisfaction in their daily work. A workplace culture of respect based on the belief that employees who feel successful, and

appreciated in the workplace truly leave their work, both physically and mentally fulfilled at the end of the day. They are thus able to better manage their time and maintain a healthy balance between work and personal life. Undergraduate BSc Nursing students would benefit more from optimum nurse to patient to student ratios.

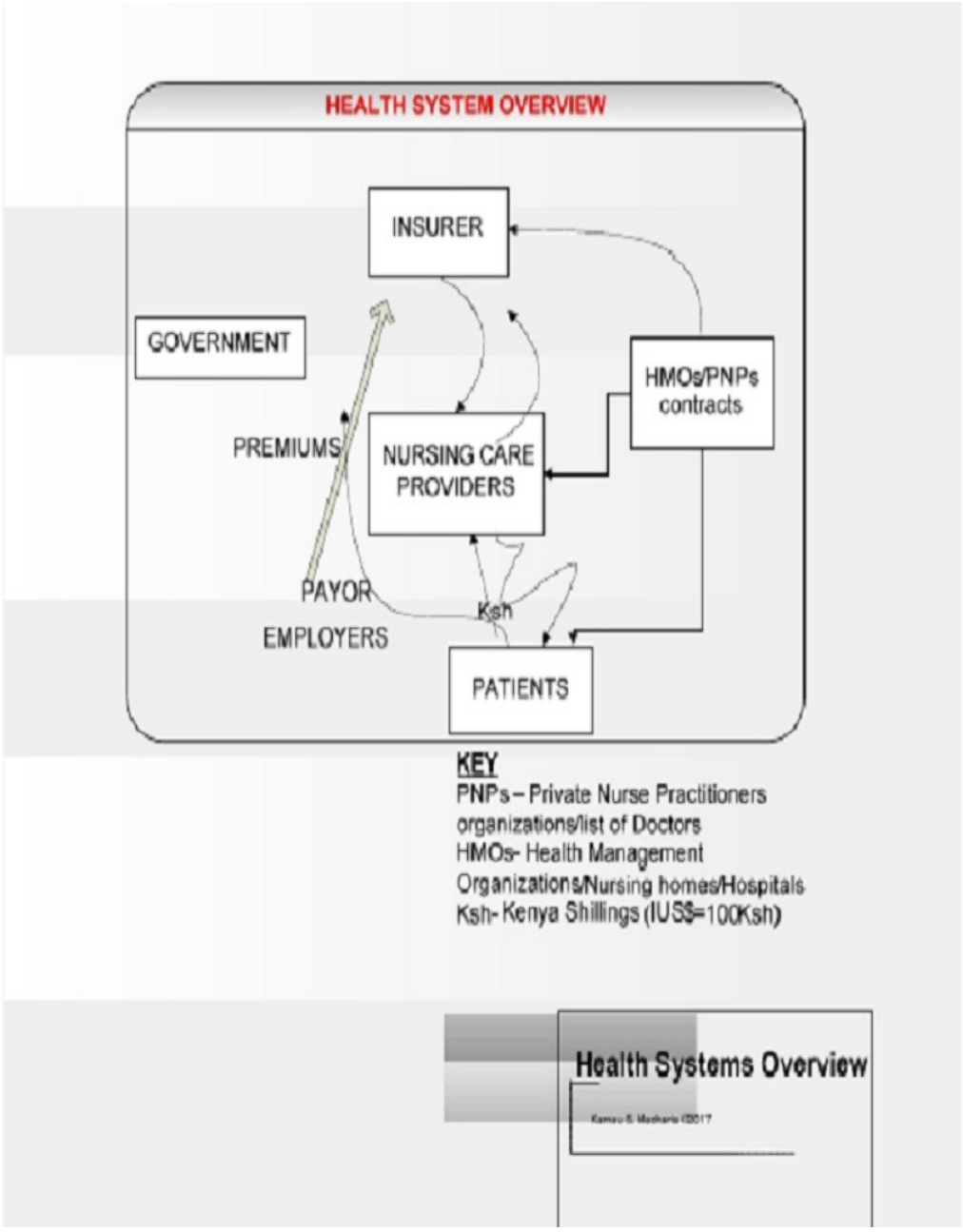


Fig: The place of nursing in the health system

13.1 Introducing Concepts Used in this Research Brief

-Researchbrief presents policy-oriented summaries of individual published peer reviewed documents. Or presentation of original research on significant policy questions. A collection and analysis of relevant information to enable policy makers to make informed business decisions. There are several formats and templates of writing one. The following is a simplified one for the purpose of this book. It is presented in the first phase of this chapter with in-text numbering chronologically.

-Annotatedbibliography differs from a standard bibliography in that it is a list of citations to books and articles that gives a brief account of the research that has been done on a given topic. It gives a summary of each of the entries it provides a descriptive or evaluative comments (annotations). There are various templates available for making one.

This chapter is modified one (perhaps not a brief at all) for purpose of this book. It is presented (numbering refers to the in-text of the research brief above it, this is not always the tradition) in the later phase of this chapter. Concordia University Library website offers good resources on research brief and annotated bibliography (library.concordia.ca/help/howto/ann...)

-Healthworkforce refers to a human resource that is responsive, fair and efficient in order to achieve the best health outcomes possible, given available resources and circumstances. Need norms/standards that govern production of sufficient staff and ensure fair distribution (HRH must be competent, responsive and productive); HRH observatories are essential for facilitating HRH management

-Workload/assignment : meaning the number of patients that a staff member can care for and complete all care safely. Workload measurement systems quantify patients' requirements for nursing care as the sum of the times of the tasks required or as the amount of time required relative to standard patients.

-Safety: Avoiding injuries to patients from the care that is intended to help them. Minimize risk of harm to patients and providers through both system effectiveness and individual performance. Remember the kindergarten where everything was 3's, model. They had three rules the children must follow, "We keep ourselves safe, we keep our friends safe, and we keep our things safe." Pretty much everything fell into these three categories. It is not any different in healthcare. Add to this safety from pilfering for all the hospital equipment and you are almost done.

-Nursingstudent: a nurse in training indexed by Nursing Council of Kenya, a novice working under a qualified Registered Nurse. An example is BSc Nursing which is a four-year undergraduate nursing degree program.

-Clinicalareaenvironment: encompasses all that surrounds the student nurse, including the clinical settings, the patients, the equipment, the staff, the preceptor nurse, and the nurse faculty It is a complex social and cognitive experience for the nursing student. It offers situational learning where the student can participate in

real life and working situations. The basic premise is how do healthcare organizations produce nursing services? How do management structures contribute to the delivery of nursing services?

-Nursingfactor: According to FierceHealth *eBook* (2014) 'How Hiring Right (Or Wrong) Has a Direct Impact on Clinical Outcomes' nurses are the biggest factor in providing better care. It also states that when experienced nurses leave, hospitals must hire fewer experiences or temporary contract nurses, leading to poor patient outcomes. The eBook examines top nurse staffing challenges and how to overcome them.

-Thelawofsupplyanddemandfornursing. There are more people leaving the field because of retirement than there are people coming into the field, and demand is increasing (Richmond Times, March 11, 2007). Some are changing careers. The highest demand for health-care professionals can be found in nursing, worldwide hospitals are always looking for experienced nurses. We need to be able to recruit a lot of the students into nursing, see more nurses graduating and passing their exams.

-Nursesensitivemeasures: According to National Database of Nursing Quality Indicators Nursing (NDNQI) that are strongly influenced by the care that nurses provide or directly measure nursing as reflected by the *structure, process, and outcomes* of nursing care. *The structure* is indicated by the supply of nursing staff, the skill level, and their education/certification. *Process* indicators measure aspects of nursing care such as assessment, intervention and RN job satisfaction. *Patient outcomes* that are determined to be nursing-sensitive are those that improve if there is a greater quantity or quality of nursing care (e.g., pressure ulcers, falls, IV infiltrations etc.). Some patient outcomes are more highly related to other aspects of institutional care, such as medical decisions and institutional policies (e.g., frequency of Caesarean sections) and are not considered "nursing-sensitive(http://www.nursingquality.org).

-Nursingeducation: The courses of theoretical and practical instruction provided to undergraduate nursing students (in this context Bachelor of Science Nursing), with the purpose of preparing them for their duties as nursing care professionals.

-NursingCare: It is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of diseases, and advocacy in the care of individuals, families, communities, and populations.

-NursingProfession: Is a vocation founded upon specialized education, training, the purpose of which is to supply objective counsel and service to others to promote health, prevent disease and help patients cope with illness. Nurses are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess and record patient symptoms, reactions, and progress.

13.1.1 Introduction

Nursing is amongst the most challenging of professions, as nurses work long hours, night shifts, and with severely ill and sometimes dying patients. Nurses have great physical endurance. On 10th May 2015 RN posted this on KNUN wall:

> *'Nurses work on a rotation basis. They can work during the morning for a few days and revert to working in the evening for a week and then a few days of night shifts before they get a day off. The timing of their shifts is such that their sleep patterns are disturbed. When they finally get the hang of a particular shift, a new one starts…other nurses have to cover their shifts. they will have to replace it later…hold on till the passing of duty to the next shift, which by the way, rarely ends as scheduled. When you're done with one difficult shift, you know there will always be another.*

According to Meyer and O'Brien-Pallas (2010) who developed *The Nursing Services Delivery Theory (NSDT)* founded on Open System Theory (Katz and Kahn, 1978) describes relational structure for reconciling disparate streams of research related to nursing work, staffing, and work environments.

In NSDT, *Size* refers to the capacity of an organization to produce nursing services e.g. numbers of beds.*Role design* assigns responsibility for particular tasks to distinct job descriptions. *Staffing practices* refer to the ways in which care activities and responsibilities are divided among nurses at the operational level based on care recipients e.g. nurse– patient ratios, *staff characteristics* e.g. experience levels, or management practices e.g. length and scheduling of shifts. *Nursing care delivery models* e.g. team, primary describe how nursing work is divided and coordinated at the work group level. *Coordination* entails mechanisms to standardize skills; *work processes* e.g. clinical pathways, or *communication methods* e.g. electronic health record.

According to International Centre for Human Resource in Nursing report 2010, Kenya has a great shortage of nurses; whereby the ratio is one (1) nurse to1345 population compared to the ideal standard ratio of 1 nurse to 250 population with barely over a thousand nursing degree holders then in the market (International Council of Nurses, 2010). But then it was possible to say that in Kenya what we had was not a shortage of nurses but shortage of working nurses. Or rather shortage of employers that treat nurses with respect.

In response to this situation, the Kenya Ministry of Health (MOH) and Public Service Commission, supported by the Capacity Project through the US President's Emergency Plan for AIDS Relief (PEPFAR), put in place an emergency hiring plan to take advantage of these unemployed nurses, doctors, and other providers. The plan created a non-governmental outsourcing mechanism to quickly hire, orient, and deploy 830 providers in more than 200 high need, public sector health centres within one year.

These workers were hired under the same terms and conditions as those working in the MOH and public service but with an end-of-contract gratuity in lieu of a pension. This equity served to minimize drawing workers away from other sectors and facilitated their

smooth transition into MOH positions when their emergency contracts ended. The Clinton Foundation had provided funding to the Kenya MOH to recruit 1,000 additional health workers using a similar approach,

Kenya Union of Nurses (KNUN, 2013) sources put the current number of nurses in the public service at 13,000 and a further 8,000 under the Economic Stimulus Package (ESP), the union further demanded that the country of 42 million Kenyans needs 172,000 more nurses in order to improve the quality of healthcare provision in government health facilities. Fortunately, these workers are being formally transferred to the public service as full-time employees and their salaries have been included in government budgets

The nurses union had galvanized the Kenyan nurses in a way no one had anticipated. Though it started off as an outfit belonging to degree nurses and perceived junior nurses this was nolonger the case. Unlike the NNAK which apparently was patronized by the older generation, KNUN is a union with membership across the age and specialty spectrum, although the younger nurses have been the main drivers and communicate a lot albeit on social media. It was possible that with time there would be a loss of institutional memory in NNAK, perhaps it was losing its relevance.

'The debate over staff-patient ratios has raged for a number of years now – with no clear or universal consensus to emerge. It is not as easy as staffing nurses unit by unit. 'We'd bring in agency nurses only to find that we didn't need them. We'd staff up to meet a perceived need only to find that we had too many nurses for the tasks at hand. We'd send nurses home on one unit while hiring someone new on another. It didn't make sense'. These were the observations by *Run your nursing department like a business.* http://healthcare.utah.edu/nursinginnovation/2011/10ideas/one.php.

Even if you work in a public hospital the bottom line still applies and we must think about it "Everything we do is for our patients. But in order to do it, our hospital must stay viable." Even if public and not-for-profit hospitals may not subscribe to financial viability, they can make their hospital nationally known for the professional practice of nursing. Identify gaps in quality, efficiency, and patient satisfaction, and use them to drive our strategy for improvement.

The Institute for Healthcare Improvement (IHI) is also a great resource, bookmarking and registering as a user of this site is a desired add-on for every health care institution as it would help us to close the gap between what is and what could be in terms of health outcomes, offer tools to help us trouble shoot on the challenges we face on an ongoing basis. http://www.ihi.org/Pages/default.aspx IHI works with local partners and governments to build their capability to use and teach quality improvement methods from the outset, ensuring the sustainability of the methodology.

Across the board observation of literature showed that there was a clear link between staffing levels and quality outcomes. Generally, the nurse-patient ratio is 1:6. Every registered nurse is given 6 patients in the general medical wards. In acute & critical care units, emergency units, CCU's 1:1 ratio is maintained. The general policy by peri-operative grand round[6] for example recommended standard for nurse-to-patient ratio of 1:4 or 1:5 on medical-surgical units, 1:3 or 1:4 on intermediate units, and 1:2 in intensive

care units. It is difficult to imagine when this will be possible for the Kijani and Zendi County Hospitals.

According to Standards of Nursing and Practice for Nurses in Kenya (NCK, 2012), the established staff to student ratio for both classroom and clinical area should meet the following: A recommended lecturer to student ratio in class room teaching of 1:10.

Recommended ratio in the clinical placement for various settings is Intensive care/high dependency unit: 1 nurse to 2 students; General wards: 1 nurse to 4 students; Long term care, health centre and dispensary clinics: 1 nurse to 6 students; and Labour Ward: 1 nurse to 2 students. Such an ideal clinical learning environment should suffice to equip the students more appropriately with the required skills and competencies for the provision of the desired level of nursing care.

These ratios would help the nurses to provide comprehensive nursing care to the patients as much as student learning with maximum patient satisfaction. The clinical experience must adequately prepare nurses into the workforce. The student nurses cannot be included in the ratios since they are novice to the profession and may not be competent enough to provide holistic nursing care to the patients.

Qualitative interviews with lecturers and tutors identified several barriers to scaling up the production of the nursing workforce[14]. These could be described in terms of limitations in clinical capacity, tutor capacity, or physical capacity.

Tutors noted difficulty with clinical placements, as current facilities serve as clinical sites for multiple institutions and cadres of health students. Tutors identified the need for clinical mentors to oversee the student nurses. Nursing faculty for whatever reason were generally not able to accompany students during their clinical rotations yet the statutory bodies (read Nursing Council of Kenya) that regulate both nursing education and practice expect faculty shall be present for student supervision while students are assigned to clinical areas.

The faculty shall select, teach, guide, and evaluate all clinical learning experiences in the clinical facilities. Generally nursing faculty currently were understaffed. In a certain KMTC campus, the nursing faculty apparently had 700 students with 4 lecturers, one LCD projector no standby generator in case of power outages. They somehow relied on trainee BSc Nursing students on teaching practice attachment. This obviously interfered with flow of content. Additionally, tutors faced logistical challenges associated with clinical placements, including transportation and accommodation for students on away rotations.

Shortages of nurses in the public hospitals have been as a result of migration, a high rate of attrition and a long freeze on civil service employment. Public-sector hiring freeze began in 1994 resulting in a shrinking health workforce that limits the government's ability to respond to increased demand for health services. Since this freeze there has existed a large (yet undefined) population of unemployed healthcare providers, especially nurses, in the labour market in Kenya.

Despite increased levels of government health spending and the lifting of the civil service employment freeze, the total number of health workers in the public service continued to decline during the last five years (HRH 2009) as a result of high levels of attrition and in particular because of retirement related losses.

Even though the retirement age for civil service had been adjusted upward from 55 to 60 years, in February 2012 the Chief Nursing Officer Chris Rakuom hinted that 60 per cent of the estimated 22,000 *nurses* in the public sector (that was about 13,000 nurses) were just about to retire. *The public sector nursing workforce in Kenya: a county-level analysis (2012)* reported that Counties were hiring nurses who were about to retire, up to a 1/3 were 50 plus years old in 20 counties, only 4% of the nurses in the country were 30 years and below. (See **Retire at 60** below).

Retire at 60

In the Mental Health Unit of a Level 6, 6 out of 13 nurses retired after attaining the age of 60 since 2012, without replacement. 2 others would be leaving in the next 2 yearsld be retiring. Against an average patient population of 70, the nurses there worked 7.30 am to 6.30 pm shifts. Getting an off was a luxury since only one nurse can take an off in any given week. In yet another 'new development' by June 2018 in Rift Valley Provincial Hospital Nakuru about 60 nurses were expected to retire.

'If there was a time nurses were going to retire, it was in the next two to five years. Seemingly, of late every other nurse I met (in the public service) shared their own apprehension related to forthcoming retirement in the coming months', a year or so'. (Source: Shared covertly by a veteran nurse).

Murang'a Tana River, Kirinyaga, Kisumu and Mandera counties in that order, had the biggest number aged 60 and above. The study carried out among all the 18,625 nurses in the public sector found Meru, West Pokot, Tharaka Nthi, Narok, and Wajir, in that order, had the biggest number of younger nurses. A flurry to recruit younger nurses by other counties, the report warns, could cripple services in poorer and hardship countries (resource-limited settings), which have the biggest number of younger nurses aged 20 to 29.

The lean staff meant that patients often waited for long periods to get attention and quality of care suffers. Staff burnout has been a problem. Despite the freeze, training institutions continued to churn out graduates who now form a significant pool of unemployed Kenyans from which to recruit.

Despite a pool of unemployed (potentially available for hire) health staff available in Kenya, staffing levels at most facilities were only 50% (Adano, *HRH 2008*). The Kenya National Union of Nurses (KNUN) has said more than 3,000 nurses had fled the country for greener pastures in two years (2012-14) allegedly due to poor salaries and working conditions. By March 2018, it was reported by KNUN that KNH had continued to use locum nurses some for over 5 years without absorbing them as permanent staff. Therefore then it was possible to say that in Kenya what we had was not a shortage of nurses but shortage of working nurses. Or rather shortage of employers that treat nurses with respect.

Emergency Hiring Program was designed as a fast-track hiring and deployment model in 2008 and later those hired under the Economic Stimulus Package (ESP), but many of the 8000 nurses were yet to be absorbed into the government payroll by the date of writing this. With a wage of Kshs 19,000 (USD$ 205) per month, in their own words, they felt underpaid and undervalued, were easy to lure away even though the country needed them most, a big loss to Kenya that had to train them but leap little in return. A good number disclosed and shared that they would readily walk out of the shabby ill-equipped outdated wards at home.

On 30th March 2016, one AWW, a finalist BSN student filed a petition (No. 01 of 2016) to the National Assembly pursuant to Article 119 of the Constitution of Kenya and national assembly standing orders. Praying it to enact the direct absorption/employment of degree nurses by the Public Service Commission.

This was by proposing to introduce a comprehensive bill that incorporated all draft policies and proposals by various individuals and associations to produce one comprehensive hybrid draft for the direct absorption consideration. It appealed for expedition for absorption of a bare minimum of only fifteen degree nurses per county in every fiscal year starting with 2015/2016.

13.1.2 County and Sub-County Hospitals

Kijani is a Sub-County Hospital (formerly Level 4 hospital) in Zendi County. Operational wise it had 200 beds and 17 cots. Bed occupancy 88% -90% per month, daily admissions 40, and average Out-patient Departments attendance was 300 patients per day. On average 238-250 mothers delivered in the hospital per month, 35-40 of whom delivered via Caesarean section. The nursing levels by mid-2015 were 65 nurses for the whole hospital. Between 2013 and 2015, 12 nurses had retired, 26 transferred out, with no replacements (Source: Office of the Nursing Officer in Charge, Kijani Sub-County Hospital, 2015).

Services offered: Antiretroviral Therapy, Curative In-patient Services, Family Planning, HIV Counselling and Testing, Immunization, Eye Clinic, ENT, Psychiatry and Orthopaedics clinics. It was the teaching hospital for University of Kue School of Health Sciences about 4 Km away from the medical campus.

It also hosted Kijani Campus of the Kenya Medical Training College in its vicinity which offered Diploma in Kenya Registered Community Health Nursing and Diploma in Clinical Medicine. Diploma in Kenya Registered Community Health Nursing from Aarqu Medical Training College (fictitious name) also undertook their clinicals there. (Source: Office of the Nursing Officer in charge, Kijani District Hospital, 2013).

It had one of the best e-health information technology LAN networks in the country. Although revenue issues, rather than clinical needs, seemed to have driven the investment in IT, sort of agreeing with Bates (2002) who observed that billing systems were generally much better than the clinical systems.

Zendi County Hospital (formerly level 4 hospital) in Zendi County. Nursing levels 120 nurses to cover for both inpatient and outpatient nursing services (Source: Office of the Nursing Officer in charge, Zendi District Hospital, 2013). Operational wise its capacity included 250 Beds and 26 cots. Bed occupancy averaged 80% for medical and surgical wards while it was about 120% per month.

A number of deliveries per month ranged between 330-380 mothers, out of whom almost 150 delivered via caesarean section per month (Source: Office of the Nursing Officer in charge, Zendi District Hospital, 2013). Services offered include Antiretroviral Therapy it hosts a Comprehensive Care Center (CCC), *Amkeni nyote Intl* (not a real name) an NGO working deals with HIV/AIDS research, Curative In-patient Services, Family Planning,

HIV Counselling and Testing, Immunization among others in the region. It was the other teaching hospital for University of Kue School of Health Sciences which is 50 Km away.

13.1.3 Nurse to Patient Ratios in the Teaching Hospitals

The University of Kue (not its real name), an ISO 9001:2008 certified institution, was one of the 21 training facilities in Kenya duly recognized and approved by Nursing Council of Kenya to train in theory and in clinical practice nurses at Bachelor's level. The health sciences programs were offered at The Kijani Campus situated within a purpose built 120 beds hospital (though not yet operational). It had witnessed high enrolments since it opened its doors in August 2011 with the first batch of 40 students in BSc Nursing and 52 in Diploma Clinical Medicine. It was worth noting that according to Universities Act 2014, universities were to stop offering diploma programs from July 2017, since these courses were offered by midlevel colleges.

A population growth of about 750 students in three years. On the other hand, teachers (lecturers, Technicians and the clinical instructors/ preceptors) have had to struggle to cope with overenrolled classes. However, these were positive outcomes for Kenya whose youthful population is about 43% of the total population (KDHS, 2011). It also meant that the numbers was likely to rise as the demand for the courses offered in the health sciences campus exceeded the number of applicants. Further, there continued to be an unmet need for those seeking to upgrade from diploma to degree in nursing and clinical medicine.



Pic: Overcrowding, bed sharing, patients on the floor, 'lay care takers' were a common sight in many public health facilities in Kenya (Picture courtesy of *Prezo Nazlin Umar* post on Face book Jan 24, 2018)

When Kenyan women parliamentarians went for a fact finding tour of the Kenyatta National Hospital during the height of #KNHrot in early 2018 they were able to establish that one maternity ward meant for 19 mothers had 93 at the given time '…may be one reason why the mothers decide to take leave and get some fresh air' perhaps endangering themselves. (*KNH Rape Claims…* by Patrick Vidua *The Star* Jan 22, 2018). The whistle blowers and victims were however not coming out clearly on the details. Either way it was important to unveil the risks, threats and challenges in terms of patient safety.

Many ails of KNH could be said were a product of dumping of referrals, nonfunctioning peripheral health facilities of Nairobi and its environs which could not guarantee even basic essential obstetrics care (WHO definition), intravenous hydration for children with diarhoea and vomiting, stitching of assault cases etc. KNH was mandated to offer specialized and subspecialized care, research and teaching etc but was weighed down this other stuff (Points gleaned from G.A. Got post shared on social media 22nd Jan., 2018).



Pic: Overcrowding, bed sharing and 'lay care takers' are a common sight in many public health facilities in Kenya (Picture courtesy of NASCOP treatment consultative conference, Nov 2013)

13.2.1 Would Legislation really help?

All nurses have horror stories about when their ratio of nurse to patient got out of hand. Whether it was by flukily luck or by some other unknown design, a facility will usually get away with doing with as few nurses for as many patients as possible. How then can a system or even the law blame a nurse who was clearly overworked? Only if there was a law to that effect.

Rarely did we have in Kenyan public hospitals a matrix that informed how many nurses could be maintained on patients' raw numbers and acuity. It seemed that some institutions based theirs on whims and common sense. Stretching the nurses to as thin as possible was the norm. Often nurses being forced to take on a group of patients that were well beyond the abilities of any normal human to care for. In any case one could do their very best and still fall short due to understaffing. An average nurse is all too human not a superhero.

A nurse could get into trouble in such situations but it should be remembered that almost in all instances it's the patients who suffer due to understaffing. It became even tougher that the number of support staff who complements nurses' work usually was literally nil to bare minimum.

However, it's never as simple as 'How many nurses are needed to care for how many patients?' There are as many as 100 different factors that have to be factored in – and situations are never static. So no one formula can suit any one situation all of the time, that's why some countries have it and some don't. Some parts of the US have mandatory staff-patient ratios e.g. The State of California went ahead to legalize a mandatory nurse to patient ratios aimed at reducing job-related burnout and dissatisfaction, decrease nurse workloads and to improve overall patient safety.

Bill AB 394 of 1999 implemented in 2004, specified the minimum number of nurses that should be staffed for each hospital unit, given the current number of patients therein. "The bill itself is not about helping employees," one dialysis nurse said. "It's about workers coming together to make sure their patients are getting the quality of care they should be getting." Nurses simply did not have the time to complete their important work.

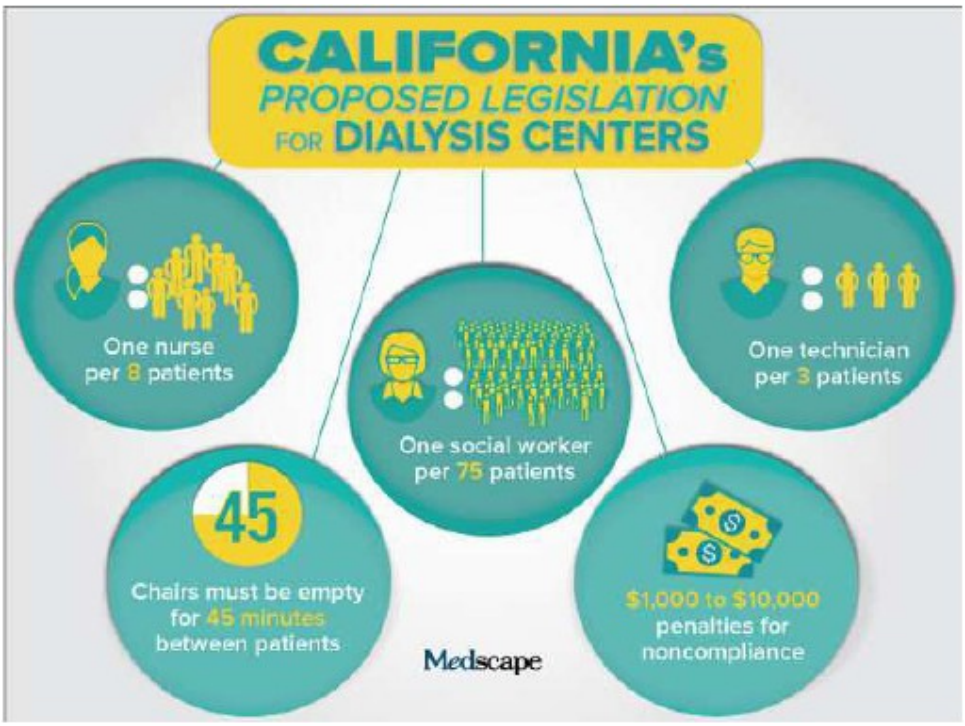


Fig: A sample of mandatory staff to patient ratios to be applied in dialysis centres in California, USA

[Courtesy of *Medscape* April 26th, 2017]

Lampert Lynda on 10th September 2013 on mightynurse.com, *Nurse Stories Series* listed 3 reasons why there was need for mandatory nurse ratios. *Protect the patient*, *protect the nurse*, *and keep facilities honest*. When someone asks, 'has the blood pressure of Mr X been taken, it was previously 180/90'. The honest answer you can give could be 'do I have a patient by that name?' What could we make of it?

Without trying to demean anyone what would be the answer to this question? Perhaps your guess is as good as mine. The best case scenario - the nurse consults the pile of files to find out about the patient, or dashes to the cubicles to call out whoever will happen to be the patient going by that name and then takes the BP pap! Why doesn't it bother the powers that be that this was one of the more common responses they had been getting for far too long? By the mere fact that there was some form of hesitation, straight way the next concern especially in acute care should be on patient's safety.

It was good to appreciate that a nurse will usually know as much as they have written down but more importantly based on their own assessment of the patient. What if they have not had a chance to settle down to countercheck all the reports they received from the outgoing shift? What if this was 4 hours or more since the nurse reported on shift?

It was not a question of how good the nurse was, remembering the particulars of tens of patients for one is not possible and it was perhaps it was not even 'safe' to pretend that one could do so. So how do the nurses manage? For the longest that this author remembers the above scenario had formed the Kenyan nurse's career life?

In any health care setting, the turnover of staff especially nursing staff can affect quality patient care due to the time is taken for the newly employed to accustom themselves to the hospital routines and policies. Turnover in health facilities had a negative impact on patient care as well as operation costs. Nationally, the US in 2014 nurse turnover stood at 20 percent, but nearly 40 percent of nurses were ready to leave their job after a single year. About 14 percent left the field altogether, and the 'working wounded' that remained were at best demoralized and at worst error-prone.

With six nurses for every physician, nursing was the heart of American health care. Nurses spend the most time with patients and are typically very dedicated. They entered their profession primarily to care for people. But nurses faced significant change and challenge in today's medical environment (Freudberg, 2015).

The nurse staffing ratio must be based on the following; the severity of illness, need for specialized equipment and technology, and the complexity of the clinical judgment needed to develop, implement, and evaluate the patient care plan, an ability of patients to provide self-care, and the licensure of the professional. Other states were not eager to emulate it and have been watching to see what happens to California, but generally different states had adopted different models, while others didn't have a model at all.

Numerous shortcomings had been noted for California such as lack of flexibility to patient acuity, skill mix and even increased nurse workload[9, 13]. Legislation is a most unlikely way to go for Zendi County any time soon[11].

13.2.2 Can student nurses be a quick fix to nursing shortage?

Nursing shortage creates demand for more nurses to be recruited, it also creates an environment that compromises on patient safety. The available nurses demand (or often get) better terms and conditions of working environment. More and more experienced nurses approach retirement age. It creates an urge for more people to want to join nursing. More nurses graduate than can be absorbed in spite of the nursing shortage. It's like a storm whichever way one looks at it. It seems to be the situation in most countries worldwide. In 2007, A La´Crosse, a health care administrator called it a "*perfect storm*" of a nursing shortage. It was also described by Talsma *et al.,* in 2008.

In Kenya, the Nursing Council of Kenya (NCK) set standards related to the education and practice of nurses. The NCK uses the Regulatory Human Resources Information System (RHRIS) to track nurses through the process of training, examination, and registration to practice nursing. As of mid-2013, the NCK had approved 83 nursing training institutions of which 53.0% were public, 32.5% faith-based and 14.5% private. Training institutions offered programs at the certificate, diploma and degree level and were located in 30 of Kenya's 47 counties.

Nurses trained at three levels, certificate (i.e. an enrolled nurse), diploma (i.e. a registered nurse) and degree (i.e. Bachelor of Science in Nursing (BScN) and off course at Masters level. From 2003-2012, 25,415 new students joined nurse training with the annual intake tripling between 2003 (1,545 new students) and 2012 (4,294). Over half of the nursing students (57.4%) got training from any of the 28 Kenya Medical Training Colleges (KMTCs), (Kenya Nursing workforce report, and the status of Nursing in Kenya-2012).

Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis. A fair and balanced patient assignment increases nurse satisfaction in their daily work. One of the factors that can be part of the formulae can be staff preceptorship with students etc. That said, student nurses are not part of the formal staff rota in most cases. They are seconded to placements mostly in an 'observational' capacity – so cannot be included in the ratio themselves.

Implicit rationing of nursing care (whether in terms of time, the number of staff or skill mix) is the withholding of or failure to carry out all necessary nursing measures due to lack of resources especially nursing staff (Papastavrou *et al.,* 2014). They added that a permanent shortage of nurses was making rationing of care an increasingly prominent feature in health care.

Nevertheless, anecdotal evidence shows several counties and hospitals were willing to start MTCs most likely in order to deal with nursing shortages in what might be considered a 'working to learn model'. Examples were Pokot County and Nairobi Women's Hospital respectively. By mid 2017 Kenya had 64 MTCs up from 27 in 2013. Current intake of 27,000 students annually and 10,000 graduating annually.

This seemed a quick patch since apparently most diploma nursing curriculums in Kenya were approximately 30% classwork and 70% practicums e.g. a 44 months basic Diploma Kenya Registered Community Health Nursing (KRCHN) program consisting of 140 weeks clinicals and 36weeks classwork. Most critically student nurses did not get any stipend commensurate to the work they did. Most hospitals instead charged the students an attachment/affiliation fee.

It was increasingly becoming necessary for students to have a personal accident insurance or other insurance (including NHIF) before being allowed to undertake attachment, internship, field visits in various facilities. Some insurance companies like Corporate Insurance Company Ltd (CIC) offered students a 3 month's spell cover for as low as Ksh 350 (approximately US$3.2) premium, details available: www.https//:cic.co.ke.

The students were exposed to long stretches of clinical placements perhaps more than were beneficial to their learning with little or no supervision from faculty who appeared to have abdicated their responsibilities. The school sort of simply hand over the list of students to the hospital to do with/to them what it saw best; which included compulsory day and night duties, balancing the staffing ratios etc.

Most of these students were in their late teens and early twenties; they did not get as much of a chance to be students but were treated as if they 'were nurses already?' At least that was what their counterparts, the BSc Nursing students thought of them. BSc nursing students seemed to enjoy more freedom from being exploited by hospitals since they were more in class. A balance between the two extremes might need to be worked out concerning nursing curriculum and its implementation. The shift would be moving from educating nurses using a hospital and content-based curricula, transforming to

competence-based curricula, provide and equip technology-rich computer and simulation laboratories and support the development of learning materials.

A good question was to ask them whether they felt that learning was taking place, the answer had usually been an astounding - No! They were working. A tutor responded that we needed to appreciate that theory background does not need to be sufficient but adequate to function. A number of these rotations e.g. 8 weeks for mental health and 12 weeks in paediatrics among others did not have an immediate assessment component (or had none at all). These left the students with little motivation to learn but to hang around 'working'. One tutor commented on the issue as follows:

> *'... they looked so lost, no clear objective as to why they are there,... after all, they know they will not be assessed, imagine a student on mental health rotation might be assigned gate key for 5 days! Maternity rotation alone was 36 weeks and 28 weeks community health?'*

> *'Class work was always such a crush program, one wondered why the hurry? Where to? A lot of student's time seemed to be wasted in the wards.'*

No wonder some of these hospitals had been known to suffer serious shortages of manpower in the months of August and Christmas season when most academic years ended or students took a break. A certain mission hospital was known to retain its graduating class from its training school for up to 6 months in what could be some form of 'internship' to offer free services. In yet another one the practice was hiring paying volunteer nurses in exchange of training experience (or rather the intern paid the hospital to do internship). While this was common practice among other careers it was catching up with nursing too.

The *XY* student's progress forms did not seem to meet their intended purpose any more. Some of these yellow forms (filled or blank except the student's name) could be found lying around somewhere in the ward drawers long after the students cleared the rotation or even graduated.

Far from being a trainee, student nurses were expected to be extremely responsible, with a litany of expectations from the staff which was mainly tedious and repetitive. Sometimes staff forgets that students are a willing but disorganized pair of hands. "You are expected to do a lot of work and are fully accountable for what happens on the wards.

If there was a huge problem, you might call your supervisor, but otherwise, you're there to work as a full member of staff" just as one student nurse was quoted in *thejournal.ie*, care should be taken while allotting patients to the nursing students for their learning experience by keeping the patient safety in mind. It would be presumptuous to expect a student to share or have an attitude of being ready to work as the staff. The priority of nursing care can better be analyzed by registered nurses than student nurses. Injuries to the patients can be avoided by close supervision of student nurses by their instructors who are assigned for clinical supervision.

A panel of student nurses' perceived intolerance and intimidating behaviours by some qualified staff who must be avoided (Porter O'Grady & Malloch, 2015). This report had analyzed various findings noting that there was a need for nurses to care for each other just as they did for their patients. Unfortunately, it has been said that 'nurses eat their young' and indeed in nursing the nurses (staff nurses and nurse managers) and not non-nurse co-workers have the greatest impact on nurses' stress. In this regard, nurses could

be are their own worst enemies and consequently, the solution to many of their problems may lie within nursing rather than outside it.

The hospitals should provide an environment where students are recognized as learners, while the students are expected to articulate their learning objectives to the staff nurses, but at the same time must be willing to be engaged and connect with patient care activities [14]

On the other hand before an RN delegates a nursing task the following criteria must be met: adequate training for the task, demonstrated learning of the task, safe performance of the task in the nursing situation, the patient's status is safe for the person (student nurse) to perform the task, appropriate supervision is available during the task implementation, and the task is in accordance with the published policy and procedure of the facility.

These were difficult to fulfil in resource-limited settings with some hospitals desperately resorting to using students to cover staff shortages. One veteran nurse observed *it was like maturing a teenage girl into a woman and a mother at the same time.*

The opposite could also be true. Some staff felt students were a bother. The nurse would have preferred that the student sat in one corner and not bother her. If there was any learning going to take place then the student could just watch.

By early November 2017 one particular KMTC had a total of 350 nursing students, comprising 7 different cohorts. This institution's teaching hospital had at some point 47 nursing students in a ward so small, one staff described it as 10 by 5 metres area-wise. When one considers that there were students from other disciplines, the congestion was unbearable for the patient and staff.



Pic: Meeting the expectations of all those seeking health care services in many public health facilities can a big challenge to an overwhelmed health care provider (Picture courtesy of Caroline Ryan)

This author happens to be a product of both the BSc Nursing and the Diploma Nursing programs and that in some way might inform some of the sentiments above. Should governance be an issue in terms of curriculum making and implementation? Stakeholders ought to make their inputs, especially alumni of the programs unlike what one cartoon satirically *when we need your opinion we will give it to you.*

13.3 Patient care at the operational level/point of service amidst nursing shortages

Balancing the acuity of the assignment evens the workload and reduces the risk of something being missed or medication errors of the nurse with a high acuity assignment. A study[3] was able to link nurse staffing, burnout, and health care-associated infections.

Nurses were at the forefront in preventing hospital-acquired infections (HAI), as these costs were not reimbursed by insurance (e.g. Medicare in the US) and were costly to a hospital. The moment a patient sets foot in a hospital, he becomes a guest whose experience will be based mainly on the good intentions of the caregiver (the host). It should then be natural that this caregiver gets properly compensated.

In their introduction, they thought that reducing burnout in registered nurses was a promising strategy to help control infections in acute care facilities since nurse staffing in the form of nurse-patient ratios and hours of nursing care per patient-day had been implicated in the spread of infection. A fatigued employed at the risk of burnout was not an engaged employee. Elizabeth Scala ably utilizes tagline "Nursing From Within" to write a blog elizabethscala.com about burnout.

RNs working in hospitals with the highest patient-to-nurse ratio are twice as likely to be dissatisfied with their position and experience job-related burnout as those working in hospitals with the lowest patient-to-nurse ratio[16]. By increasing RN staffing levels and thereby lowering the patient-to-nurse ratio, hospitals could reduce turnover rates by decreasing the job dissatisfaction and burnout that may lead to resignation.

Everyone remembers some burn out sometime? Imagine now how that could lead to more infections in your unit. Care at the bedside calls for a certain level of team relational communication as exemplified by bedside report as was shared an item on 'Teamwork' by a nurse friend in this author's network (see **Teamwork** below).

> ***Teamwork***
>
> *When we implemented bedside report, we did implement a checklist of "must haves" that included introductions to the patient, safety checks (double-checking medications, wristbands, etc.), and meeting the patient's immediate needs, and letting them know that the new RN would come back within a certain time frame. Additionally, if the family were in the room, they were invited to be part of identification/introductions. We found that the process of implementing bedside report (like many other things) is only truly effective if it is done consistently. Meaning that explanations about what the patient was going to see/hear/do during this time were consistent from shift to shift and regardless of who the nurse was. That is why the checklist became so important in our unit. Physician and nurse relationships must exude teamwork, understanding, and solidarity.*

The results indeed found that there was a relationship between nurse staffing and patient infections acquired during hospital stays as follows: looking at it in a little detail, overall; 16 patients per 1,000 acquired some type of infection while hospitalized [3]. The most common infections were urinary tract infections (8.6 per 1,000) and surgical site infections (4.2 per 1,000), followed by gastrointestinal infections (2.5 per 1,000) and pneumonia (2.1 per 1,000).

It clearly indicated that differences in nurse workloads across hospitals were associated with the rate of patient infections. That increasing a nurse's workload by 1(one) patient

was associated with increases in both urinary tract and surgical site infections.According to a Southampton University (UK) study on 31 NHS Trusts reported in *The Telegraph* on 23rd August 2017, every extra patient on nurse's caseload increased death risks by 7%. Further, a 10% increase was associated with a 16% likelihood of death following common surgical procedures.

The study found that there were far higher death risks in understaffed hospitals Lack of caretaking time was found to be the 'missing link' that somehow determined the rates in different hospitals. Shortage of staff meant that crucial tasks - administering medications, detecting patients who were deteriorating went undone. 'Missed nursing care', or 'important care' that should have been delivered but was not, was widespread. The norm was 8 patients per nurse but it often went as high as 18. In a way the patient paid the highest price (life) when authorities economized on nurses or employed less qualified/less experienced ones.

The reader might agree that there are tensions involved in nurse staffing ratios and patient safety especially since RN staffing census has usually been low many times. Whenever RN ratios were adhered to, patients received safe, quality care. There was little doubt this was so when the patients were asked. Studies[6] had demonstrated that increases in the number of RNs caring for patients resulted in fewer complications, lower morbidity, fewer medication errors, and lower costs.

Duffield[5] did a great piece on nursing staffing, nursing workload, the work environment and patient outcomes as a 5(five) year longitudinal study. In their introduction, they observed that nursing staffing (fewer RNs), increased workload and unstable nursing unit environment were linked to negative patient outcomes' including falls and medication errors in medical surgical units.

A healthy work environment is one in which there is not only absence of harmful conditions but an abundance of health promoting condition (derived from WHO 1986 definition of Health). How do we to ensure a healthy work environment? Continuous assessment of risks to health; Appropriate provision of information and training on health issues; Availability of health promoting organizational support practices.

For the nurse a positive work environment might include: Work autonomy and clarity of roles and responsibilities; Sufficient resources; Recognition of work and achievement; Manageable workload and effective workload management; Supportive management and peer structures; Effective management of occupational health and safety risks including a safe and clean workplace; Effective employee representation and communication; Maternity/paternity leave; Enforced equal opportunity policy; Sustainable employment (security of tenure); Personal security.

Evidence on the positive effects of higher proportions of RNs on patient outcomes in CCU and surgery was strong and consistent[1]. Higher RN staffing was associated with less: hospital mortality, failure to rescue, cardiac arrest, hospital-acquired pneumonia, and fewer adverse events. Conversely, lower levels of RN staffing were associated with higher rates of urinary tract infections, pneumonia, shock, cardiac arrest, upper GI bleeding, failure to rescue and increased length of stay (ALOS).

Time dedicated to actual nursing care is astonishingly becoming less. One study measured sources of nursing inefficiency in the medical-surgical setting[7], and revealed that the majority of nursing practice time was accounted for by documentation (35%), medication administration (17%), and care coordination (21%), with only 19% of nursing

hours, on average, being consumed by actual patient care[2]. This being the case then the statement below might make us see the seriousness of the situation.

One result of increased workload[7] was that basic nursing interventions e.g. comforting, skin care, oral hygiene, documentation, teaching of families were left undone or delayed in the case of answering call bells, vital signs, pain medications, dressings, turning, measuring/documenting intake and output mobilization and dressings. Imagine core nursing undone [7].

There is, therefore, need to eliminate those tasks that do not add value to unit operations or care outcomes. They should not interfere with the delivery of high-quality nursing care. You might want to list some of them.

If we relate these comments to our situation, it is a sad fact that a nurse, even a compleat, outstanding nurse can only do one thing at a time. Clinical work is naturally chaotic, the nurse moves from task to task focusing on what is important, when a more important problem surfaces, she stops what she was doing to deal with it. When she's not running off to help someone else she is trying to "fit one more thing" into an already hectic routine? These results in perturbation; amount of time completion of a task is postponed.

It was ok to tell/ even write to the seniors that you are having a bad time. It's important that they should come to terms with the fact that the situation won't improve by just working harder. But then, how do we expect that the patients too will understand this to adapt? Would it be such a pipe dream to imagine a time when the patient can see what we are going through and vouch for us right there? That they do see that we were doing our best in the circumstances and that something needs to be done.

Even the best of effort is only a singular contribution to the journey for the greater good that we refer to as quality health care. For example, if six patients in a 42-bed Nyayo ward all press their bells at once and there was only one nurse on night duty as is sometimes the case for our teaching hospitals, five may not be answered.

> *"If a patient hits the call bell and no one is at the nurse's station, did it really make a sound?"* - Unknown, RN

On 25th February 2015, DB posted on KNUN wall (see **All alone** below).

> **All alone**
>
> Day 4 of my night duty.... Feel so fatigued whereas hv got 3 more days to go... Am all alone in ward of 50+ patients… Am supposed to give Rx, document, order drugs, if an admission comes niachanishe trolley ya dawa so that I receive the patient, give nursing care... etc... Asubuhi I take all the obs, cardex n tally thm all... feel lyk quitting ths job. (Interpretation from Sheng- Swahili-English colloquial, Rx is for treatment or the task of doing a medications round). 'This is the fourth night I am on duty, already I feel so fatigued though 3 more nights to go. I am all alone in the ward which has over 50 patients. I am supposed to give treatment, order drugs, document etc. If a new admission gets here I have to stop what I was doing to attend to it. In the morning I do allthe observations, write the cardex and enter them, I feel like quitting this job'.

When nursing demand/supply levels exceeded 80%, the number of negative outcomes increases not only for the patients but for nurses and hospitals[10]. Nurse overtime working hours were positively associated with increased negative outcomes not only for the

patients but for nurses and hospitals. Mandatory overtime and night shift in a predominantly female profession raises significant issues, such as the difficulty of meeting both professional and family responsibilities. When the patient- nurse ratio exceeded 7:1 worse things can happen [16].

There was a direct relationship between nurse staffing and patient well-being. Nurses serve as an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing RN staffing.

The results of the study implied that had Pennsylvania instituted a state-wide nurse-to-patient ratio of 1:4, possibly 4,000 of the 232,342 patients studied may have died within 30 days of being admitted; had it been 1:8, more than 5,000 may have died. A more recent study done in South Africa[4] concluded that it was by improving the practice environment, including patient to nurse ratios that held promise for retaining a qualified and committed nurse workforce that may benefit patients in terms of better quality care.

A study [12] comparing China and Europe found that substantial percentages of nurses described their work environment and the quality of care on their unit as poor or fair (61% and 29%, respectively) and graded their hospital low on patient safety (36%). These outcomes tended to be somewhat poorer in China than in Europe, though fewer nurses in China gave their hospitals poor safety grades. How would our teaching hospitals fare in this one?

Nursing is important in quality and safety of hospital care and in patients' perceptions of their care. Improving quality of hospital work environments and expanding the number of baccalaureate-prepared nurses held promise for improving hospital outcomes in China[12]. Degree nurses are barely 1000 in Kenyan hospitals but we want to believe that they would make that difference.

From the perspective of nursing education: if a nurse has too heavy an assignment he/she cannot effectively mentor a student[14]. Having a student to guide with an overly heavy workload creates additional stress and distraction to the nurse and may increase risks such as those mentioned above.

In 1996 and 1997, the Ministry of Health oversaw the direct absorption into public service of the pioneer groups of degree nurses. Currently, the public sector has a total number of 22,000 nurses overall against a population of approximately 43,000,000 Kenyans. But since 1999, successive regimes hardly advertise for these positions thus foregoing the potential benefits that come along with this cadre of professionals in the healthcare system.

Degree nurses are prized for their skills in critical thinking, leadership, case management, and health promotion, and for their ability to practice across a variety of inpatient and outpatient settings. Many organizations worldwide recognize the unique value that a degree prepared nurses bring to the practice setting. Ann Kutney Lee and colleagues (2013) was one of the many such studies which had come up with findings that showed how patients, employers, and the profession benefitted when nurses advanced their education.

13.4 It is a battle worth fighting

Nurses worldwide are fighting to create better health care settings and coping with a loss of stability and an increased workload. Nurses are well placed to advocate for quality professional practice environments in today's health care system [9].

Considering patient acuity can more accurately determine the workload. Six low acuity patients are much easier to manage and creates less work stress for the nurse than 6 (six) total care patients. A consensus statement on safe staffing levels by the Nursing Standard's Care Campaign[9] ran a captivating 'Eight patients per nurse is unsafe'. The alliance argued that if a nurse on a general medical or surgical ward were to be asked to care for more than eight patients on day duty, this should be reported as a clinical incident.

The alliance presented the case to ministers for safe minimum levels of nurses on hospital wards, backed by evidence-based methods. Nursing leadership is facing a great challenge in advocacy on this issue. Luckily, in the US they managed to recruit others into their course e.g. Institute of Medicine[8] and advocacy groups in the political class.

This approach will become important as we explore outcomes sensitive to nursing practice as relates to workload and scope of practice [15]. A political connection with someone who gets along with their peers is an advisor that can grease the wheels for you if you have issues during the course of your proposing and petitioning the national or county assembly.

'Creating a safe and effective environment for your patients can begin at the bedside but opening new pathways to improving patient care is advanced through advocacy', observed Kaitlyn Gregory *DNP* (2017). Calling on the nurses to rise to the occasion to lead change, give forward experience by highlighting the important role nurses play in advancing health care. Writing in today's version of *Nursing Notes* hosted by Johnsons & Johnsons (available: www.DiscoverNursing.com). Dr. Kaitlyn a clinical nurse specialist in Philadelphia US received an award for *Giving Excellence Meaning* (GEM) in 2016.

Advocacy and activism seem something nurses can do here in Kenya. For instance to draw attention to one of the biggest challenges facing the nursing profession today: unsafe nurse staffing. In advocacy it would be good to appreciate the not all issues have the same weight – *'some arguments you have to hold with a belt and a suspender, because one is no adequate on its own'* as Kenya's Senior Counsel Ahmednassir Abdulahi used to say.

The timing was ripe since health services have now been devolved (albeit with a lot of aggrieved parties involved) to county level with the 2010 constitution dispensation. We can access Zendi County Governor, Senator and Chief Officers of health with ease to lobby their support for nurse-to-patient ratios in hospitals, nursing homes, and the facilities that nurses worked in on a day-to-day basis. Much of the formal training even at Masters level in health-related programs apparently contained insufficient emphasis on policy-related competencies.

13.5 The gap and steps we can take

It is fascinating that this information might appear repetitive, but it helps to tell a story, but that story is only as good as the interventions we can take to make improvements. Unsafe staffing is an issue that affects everyone at some point. When there are not enough nurses to take care of the patients, it was unsafe for both patients and nurses. Mistakes are made, patients have more complications, and more patients die.

Nurses suffered more workplace injuries and feel harassed in the workplace. They become burned out and may exit the profession prematurely. The gap that needed to be addressed was that much of the data accessed was derived from USA, Europe, China and Taiwan and only a few from Africa. It was therefore important to look critically at which of those factors could apply to our situation.

Staffing patterns in these countries and ours may be different but I believe the number of patients assigned and how they are assigned and to whom they are assigned transcend geographic boundaries. It does also affect the students learning in the practical areas (wards, laboratories, and clinics etc.) since staff who are over-stretched are less likely to give much attention to teaching. In the hospital setting the nursing preceptors or mentors are vital for orienting students and new nursing staff. Ideals and values may not get much of a chance.

The nursing students will most likely have to improvise procedures and cover for the shortage of manpower at the expense of learning. This was the reality that even our students had been brought up in - that healthcare organizations need to work using less to achieve more. Appreciating that there was what was known and what was done in practice or some know-do gap. More often than not the ideal remained more of simulation/theoretical than a reality in practice. This was not the same as working smart (Please see **clean gloves or sterile gloves** in Chapter One).

We need to understand how to use this data towards evidence-based practice, by developing an intuitive grasp of situations and quick targeting of problem areas since nursing staffing shortages in Kenyan public hospitals is not likely to end any time soon[11]. Organizations need to recognize that working nights is a necessary evil and they need to make sure there are incentives in place that make people want to work the night shift and compensate for people's changes in their lives and for their families.

From this research brief, it is clear that there was adequate research on the subject. Based on these, we can generate more information to gradually implement a plan to change our work environment. Beginning with advocacy, making a case for ourselves, but we need to articulate these issues based on our data. Developing a factual base for your opinions ensures an informed dialogue with others, supports your views with hard data or factual evidence to increase your credibility.

The great thing was that medical related courses still hold the premise of being market driven ventures and continued to attract many school leavers. Pubic as well as private hospitals have been getting accreditation as medical training colleges training institutions for nurses, midwives and laboratory technicians. Through affiliations to universities their graduates could transition vertically to degree level. What remained it seemed was absorbing them, increasing the staff student ratios.

13.6 Begging Questions

Utilizing Quality Health Care Organizing Framework for Resource-Constrained health care settings in Kenya the following might need to be looked at critically:

(1) How can we make our work environment safe for our patients, students and for ourselves?

(2) Lay care providers (including relatives 'caretakers') whether they do assist with care or usurping, complementing or substituting nurses work, cover shortages; sort of lowering the cost of providing services by shifting tasks from health care providers to less specialized community members.

(3) The congestion in the wards, patients sharing beds overcrowding and what it means for staff; when can a nurse in a public hospital ever say the ward has a maximum number of patients and can admit no more?

(4) At what point can we say that a hospital can no longer absorb more students?

(5) How can we make the nursing curriculum more user-friendly to the two most important clients- the student and the patient?

There were a lot of staffing issues in research that could be applied in the two teaching hospitals and nurses might be interested in a staff-understandable review of what has been researched. Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis. A fair and balanced patient assignment increases nurse satisfaction in their daily work.

Undergraduate BSc Nursing students would benefit more from optimum nurse to student to patient ratios. Interventions seeking to optimize the ratios of nurse to patients should be comprehensive, as increases in nursing students recruitment will only be feasible if the limitations in clinical placements, faculty capacity, and physical infrastructure were simultaneously addressed.

> While addressing a group of nursing students on an education tour of the western region of Kenya during the height of one of the protracted industrial action in 2017 by medical staff. A county health official observed, *'hata nyinyi mtakuja tuta-strike na nyinyi,* when you will come out you will find out why, because health is not a priority to them especially the county government'. Paraphrased from colloquial Swahili- English (Sheng): when you students will have graduated to join the service, strikes will continue since as it is health sector was apparently less of a priority in as far as county authorities were concerned.

May be the reason why a nursing faculty was heard to often say to the students, 'this is theory we have just finished, pray it to your God that you will meet it somewhere else'. But then at the end of the day, we are also consumers of the products (graduates) that we produce and release into the health system. It was becoming increasingly common that in some fields (possibly including nursing) graduates needed to be retrained in order to become employable. Others needed some 'panel beating and spray painting' one employer quipped.

If we could help to form knowledgeable and well-rounded nurses of tomorrow. If we could find the compleat nurse (discussed in Chapter 1) who has a profound piece of mind, willing to teach and describe his/her thought process on how one gets to certain conclusions, we could be sure that our future nurses are in great hands. It's those amazing people that help make the world go-round!

No conventional work could be accessed with the phrase *compleat nurse*. However, some seminal work made mention of a compleat nurse. The earliest that this author found in part was *Aristotle's Compleat and Experienc'd Midwife* by W-S-, MD. alias William Salmon (1644-1713). In one quote he wrote. '...And yet if you don't meet with one altogether answering this description, he may be a good *Nurse* for all that; but the nearer to this, the better. But this is not at all...'

13.6.1 Any hope then?

According to 20^{10} IOM Future of Nursing Report "Strong leadership is required to realize the vision of a transformed health care system…"The nursing profession must produce leaders...from the bedside to the boardroom."— By increasing the number of nurses on hospital/health system, policy, and organization boards. Nurse leaders can provide a valuable perspective that balances the business needs of health care with clinical and patient outcomes.

Their role in decision-making can also have a direct impact on the quality and safety of care. One source that appealed to me was from the University of Utah Hospital that was entitled *Run your nursing department like a business* Improve efficiency—and quality—with smaller, more flexible units. Available: http://healthcare.utah.edu/nursinginnovation/2011/10ideas/one.php:

This was what they said: We put our entire nursing department on a centralized staffing grid and made hospital-wide staffing decisions based on our census status to ensure an ideal nurse-to-patient ratio. With this one change, we were able to optimize our staffing 24 hours a day.

To further improve efficiency and staffing, we designed each of our new units with three smaller pods and three separate nursing stations. Now, if our census is low, we can simply shut down a pod—so we don't have to staff up on a unit that's not fully loaded. Our pods also allow us to co-locate patients based on their clinical needs, so we can assign specialized nurses to very specific areas.

What's more, the smaller pods keep nurses in closer proximity to their patients and create a quieter and less chaotic environment. "It's a great way to give more personalized care," "And it's incredibly cost effective." With centralized, global staffing and smaller, flexible nursing pods on each unit, University of Utah Hospital had a healthier financial outlook than ever before, taking care of 11% more patients with 4% less labour - a reduction in nursing labour costs of $100(Kshs 8,600) per patient day.

IOM Roundtable Report (2007) recommend that one of the means to ending nursing shortage could be if workflow was predicated on the principles of evidence.

This was the strategy they applied. *Improvement is a science*: They had developed each of their creative nursing ideas with a structured, systematic approach. Here's how they did it:

- Analyze the data. Listen to staff concerns, examine financial performance data, and pinpoint any gaps in quality or patient safety.
- Develop a pilot. Try out the new idea on one unit and measure results.
- Expand the program. Bring the idea to other units after a pattern of success has been established with the pilot.

13.7 Detailed Search Strategy

An integrative review of literature to identify a maximum number of eligible articles from databases with key terminologies, networking and searching journal registries.

13.7.1 Limiters

-Years 2003 to 2013 (2 exemptions of 2001 from Institute of Medicine-IOM booklet and Hagedorn model on politics in care, 1995).
-English Language

13.7.2 Expanders: Applied related words

After using "Workload", "Quality of Health Care+", "Nurse-Patient Ratio", and "Patient Outcomes" as keywords, reports were initially excluded if workload was discussed in terms of integrating a new policy in the workplace or if patient care was not addressed. I was able to use CINAHL and PubMed databases primarily (as seen in the table below) and then expanded my search using "Find it" and recommendations from others in my workforce.

I also looked at endnotes of articles for further links, especially at the abstracts. I believe other data bases might have expanded this view and will be looking into them in future. By focusing the review, potentially relevant sources identified were reduced from 3982 to less than 20 reports. So far I have 15 as presented in annotated bibliography below. Further readings are also provided in Appendix below.

One author Aiken, L[4, 12] did more than two collaborative articles on the topic. Therefore based upon my search there does not seem to be many authors concentrating on this topic. Position statements from various professional bodies cited the works of authors now and then.

What was fascinating was that they seemed to be saying one and the same thing i.e. information might appear repetitive from the reports. This was a notable weakness on my search namely; no new issues coming up. Authors from far-east Asia also seemed to be making some impact in this area of workforce (interesting I had some difficulty citing their names). I did get two articles from Africa (one report from Kenya) which was rather disappointing. It would be interesting if we were to relate this environmental factor of nursing shortage to congestion in the wards; patients sharing beds; the role of lay care providers.

13.8 Annotated Bibliography

1. American Association of Critical-Care Nurses 2005, Web Site www.aacn.org

AACN is an authoritative professional body for nurses working in intensive care units in the US. They assert that negative, demoralizing and unsafe conditions in workplaces could not be allowed to continue. The creation of healthy work environments was imperative to ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability.

2. Birmingham, S. (2010). Evidence-based staffing, the next step. *Nurse Leader*. Mosby Inc.

This article by Birmingham, S. (2010) stated that there was strong evidence of the impact of nurse staffing on patient safety and quality. That there was the right nurse who may be assigned to right patient(s) for an equitable distribution of care hours and fairness in workload. That fair and balanced patient assignment increased nurse satisfaction in their daily work.

3. Cimioti, J. (2012). Nurse staffing, burnout, and health care-associated infection. *American Journal of Infection Control*. Elsevier: 40. 486-90

This study [3] was able to link nurse staffing, burnout, and health care-associated infection. In their introduction, they thought that reducing burnout in registered nurses was a promising strategy to help control infections in acute care facilities since nurse staffing in the form of nurse-patient ratios and hours of nursing care per patient-day had been implicated in the spread of infection.

For purposes of this review, it was notable in the Cimioti study that differences in nurse workloads across hospitals were associated with the rate of patient infections. That increasing a nurse's workload by 1 patient was associated with increases in both urinary tract and surgical site infections.

4. Cotzee, S., Klopper, H., Ellis, S., Aiken, L. (2013). A Tale of two systems-nurses practice environment, wellbeing, perceived quality of care and patient safety in private and public hospitals in South Africa: a questionnaire survey. *International Journal Nursing Studies*. 50(2):162-73.

Closer home this study[4] done in South Africa concluded that it was by improving the practice environment, including patient to nurse ratios that held promise for retaining a qualified and committed nurse workforce and may benefit patients in terms of better quality care.

5. Duffield, C, (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*.Elsevier. 24, 244-255.

This was a great piece on nursing staffing, nursing workload, the work environment and patient outcomes as a 5-year longitudinal study. In their introduction, they had observed that nursing staffing (fewer RNs), increased workload and unstable nursing unit

environment were linked to negative patient outcomes including falls and medication errors in medical surgical units.

6. Girard, N. (2013). Perioperative grand round, nurse staffing ratios. *AORN Journal*. *97* (5): 604.

Girard outlined the general policy by peri-operative grand round; nurse staffing ratios. The recommended WHO standard for nurse-to-patient ratio of 1:4 or 1:5 on medical-surgical units, 1:3 or 1:4 on intermediate units, and 1:2 in intensive care units. Girard alluded that there were tensions involved in nurse staffing ratios and patient safety especially since RN staffing census was found to be low many times. When RN ratios were adhered to, patients received safe, quality care. Studies had demonstrated that increases in the number of RNs caring for patients resulted in fewer complications, lower morbidity, fewer medication errors, and lower costs.

7. Hendrich, A., Chow, M., Skierczynski, B., Lu, Z. (2008). 36-hospital time and motion study: How do medical-surgical nurses spend their time? *Permanente Journal.12* (3):25-34.

Hendrich measured sources of nursing inefficiency in the medical-surgical setting and revealed that the majority of nursing practice time was accounted for by documentation (35%) medication administration (17%), and care coordination (21%), with only 19% of nursing hours, on average, being consumed by actual patient care.

8. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press. (2001). Available at: [http://www.nap.edu/books/0309072808/html/]

A key statement by the Institute of Medicine, 'Health care is not just another service industry. Its fundamental nature is characterized by people taking care of other people in times of need and stress. Stable, trusting relationships between a patient and the people providing care can be critical to healing or managing an illness'.

9. Kay, J. (2013). 'Eight patients per nurse is unsafe'. *Nursing Standard*. *27*(37): 18 RCN Publishing Company.

I found Kay's a sound resource since it was a more recent, current double peer reviewed article containing a consensus statement on safe staffing levels by the Nursing Standard's Care Campaign. It ran a captivating 'Eight patients per nurse is unsafe'. The alliance presented the case to ministers for safe minimum levels of nurses on hospital wards, backed by evidence-based methods.

10. Li-Fang, L., Sheuan, L. (2012). Exploring the association between nurse workload and nurse-sensitive patient safety outcome indicators. *Journal of Nursing Research*. *20* (4): 300-309.

The results from Taiwan concluded that nurse workforce and nurse-sensitive patient outcome indicators are positively correlated[10]. Nurse overtime working hours were positively associated with the following nurse-sensitive patient safety outcome indicators: patient falls, decubitus/pressure ulcers, near errors in medication, medication errors, unplanned extubation, hospital- acquired pneumonia, and hospital-acquired urinary tract

infections; risks of patient falls, decubitus/pressure ulcers, unplanned extubation, hospital-acquired pneumonia, and hospital-acquired urinary tract infections significantly increased when the patient- nurse ratio exceeded 7:1(see Iowa Model in Chapter 8.4).

World Bank Group: Service Delivery Indicator Survey (SDI) July 2013. This survey released recently on frontline health care providers in Kenya underscored the reality about shortage of nurses in Kenya.

11. You, L., Aiken, L. (2013). Hospital nursing, care quality, and patient satisfaction: cross-sectional surveys of nurses and patients in hospitals in China and Europe. *International Journal of Nursing Studies*. 50(2): 154-161.

You and colleagues found that substantial percentages of nurses described their work environment and the quality of care on their unit as poor or fair (61% and 29%, respectively) and graded their hospital low on patient safety (36%). These outcomes tended to be somewhat poorer in China than in Europe, though fewer nurses in China gave their hospitals poor safety grades. Improving quality of hospital work environments and expanding the number of baccalaureate-prepared nurses hold promise for improving hospital outcomes in China.

12. Pamela, T. (2011). Mandatory nurse: patient ratios. *MedSurg Nursing*. 20(5):265-68.

This writer was giving the scenario on how the state of California went about instituting the mandatory nurse to patient ratio. There were several misgivings on the effectiveness of such a move.

13. Kenya's Health Workforce Training Capacity: A Situation Analysis. (2010). UNFPA.

To address the shortage of health care workers, Kenya has employed various strategies including emergency hiring program and online upgrading courses. Due to the shortage of nurses, staff nurses have limitedtimeto teach student nurses. Retrieved; www.unfpa.org/sowmy/resources/docs/library/R200_KenyaHealthWorkForce_2010_HealthWorkforceTrainingCap

14. Hagedorn, S. (1995). The politics of caring: The role of activism in primary care. *Advances in Nursing Science*, 17(4), 1-11

Activism in primary caring promotes exposing, provoking, and unbalancing the social power that maintains people in a state of disease, while simultaneously nurturing caring. Activism provides the knowledge and means of redressing the social inequalities that maintain an environment of disease. Florence Nightingale wrote, "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle" (Notes on Hospitals).

15. Aiken, L., Clarke, S., Douglas, S., Julie, S., Silber, J. (2002). Fact Sheet 2003–1. The Aiken Study: Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, Vol. 288, No. 16, October 23–30

Clear Link Between Staffing Levels and Patient Success. The study found that for each additional patient over four in a nurse's workload, the risk of death increases by seven percent for surgical patients. Patients in hospitals with the highest patient-to-nurse ratio (eight patients per nurse) have a 31% greater risk of dying than those in hospitals with four patients per nurse. On a national scale, staffing differences of this magnitude may result in as many as 20,000 unnecessary deaths each year.

13.9 A Policy Brief: THE NURSING SITUATION IN KENYA: PATIENTS DESERVE BETTER CARE

According to International Council of Nurses (ICN, 2012), nurses were excellent at giving care and at solving immediate problems, often with few resources. They interacted with consumers of health care in a wide variety of settings. This gave nurses a broad understanding of health needs of how factors in the environment might affect the health situation for clients, families, and community.

They are conversant with how people might respond to different strategies and services. Yet, nursing had difficulty getting this message out to policy-makers. ICN proposed that national nurses' associations were best positioned to influence policy by bridging the bedside to boardroom divide. One way to do this is to develop policy briefings policy issues, lobby for more nursing input into health care decision-making.

Using EBP they can develop policy briefings that can make a case, present the key messages and identify the needed support. The following policy brief was written by this author and posted to (1) The Cabinet Secretary, Ministry of Health Kenya (2) The Chairman, Council of Governors Kenya

THE NURSING SITUATION IN KENYA: PATIENTS DESERVE BETTER CARE

A Policy Brief to (1) The Cabinet Secretary, Ministry of Health Kenya &

(2) The Chairman, Council of Governors Kenya

Introduction

Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing nursing staff. While increasing a nurse's workload by 1(one) patient was associated with increases in urinary tract & surgical site infections, patients' fall and failure to rescue[61].

-Kenya had the ratio of one (1)nurse to 1345 population (International Council of Nurses, 2010).

- World Health Organization recommends averageof 22.8 nurses per 10,000 people for optimal delivery of services

Implication

A consensus statement on safe staffing levels by the Nursing Standard's Care Campaign[2] stated *'Eight patients per nurse is unsafe'*. The alliance

[61] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press. (2001

argued that if a nurse on a general medical or surgical ward were to be asked to care for more than eight patients, this should be reported as a clinical incident[2]. If six patients in a 42-bed Nyayo ward all needed help at once and there was only one nurse on (night) duty as is often the case in many public hospitals, five may not be answered. A health care-related mistake becomes more likely, while a just-in-time intervention is unlikely. High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers (Human Resource for Health Kenya, 2009-2012).

One result of increased workload [62] was that basic nursing interventions e.g. comforting, skin care, oral hygiene, documentation, teaching of families were left undone or delayed in the case of answering call bells, vital signs, pain medications, dressings, turning, measuring, documenting intake and output, mobilization and dressings. Only 19% of nursing hours, on average were consumed by actual patient care[2].



A nurse at work in a general ward: Picture courtesy of WHO

Recommendations

Nursing ratios should be adhered to ensure safe, quality care. 172,000 more nurses needed from 21,000 (Kenya National Union of Nurses, 2013). By 2016, there were 45,018 nurses, midwives in Kenya a ratio of 13.8 nurses per 10,000 patients (WHO recommended 44.5 per 10,000) [Source, MOH, WHO]. Unless the nursing situation was addressed as a matter of urgency there is going to be a challenge in succession planning i.e. passing on the baton to the next generation:

*Require Kenyan hospitals to develop and implement minimum standards for nurse: patient ratios that take into account patient acuity,

[62] Kay, J. (2013). 'Eight patients per nurse is unsafe'. *Nursing Standard*. 27(37): 18 RCN Publishing Company

*Different counties should consider ordinances to ensure nursing staff norms at absolute levels, below which it's possible to raise the red flag,

*Implement incentives to increase the nurse workforce in Kenya, including scholarships, tax incentives, etc.

*Implement incentives to retain and motivational mechanism the existing nursing workforce in Kenya, including paid internship and residency programs for all new graduates,

*Funding the establishment of new nursing schools in Kenya,

*Both national and county governments must create an enabling environment to every Kenyan to access acceptable, high-quality healthcare.

Detailed Search Strategies

The table below was may not necessarily be part of the briefs but meant to add value to the reader's understanding on how part of the literature review was accessed.

-the research brief has been amplified in this chapter, therefore not a brief any more, while the policy brief above has remained as it was except for the photograph *A nurse at work in a general ward.*



Pic: Students and staff sharing in a continuous professional development (CPD) session
(Courtesy of Community Eye Health Update)

Detailed search strategies that was used in research brief & annotated bibliography

CINAHL	(MH "Workload")OR (MH "Quality of Health Care+") AND
	(MH "Nurse-Patient Ratio") OR (MH "Patient Outcomes")
HINARI PubMed	This strategy is limited to "developing countries." I got o 13 citations and utilized one from South Africa. ("Developing Countries"[Mesh] OR "Africa"[Mesh] OR "Asia, Central"[Mesh] OR "Asia, Southeastern"[Mesh] OR "Asia, Western"[Mesh] OR "Developing Countries" OR "Africa" OR "Kenya" OR "East Africa" OR "South Afric OR "Tanzania" OR "Asia" OR "Central America" OR "South America")
	AND
	(("quality of health care" or "patient safety" or "burnout"))
	OR "Quality of Health Care"[Mesh] OR "Patient Safety"[Mesh

KEY: (MH) medical heading; [Mesh] medical sub-heading

Filters: Journals, English, year, author

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CHAPTER 14

Utilizing Theory and Evidence to Deliver Care VI:

Lay Care Providers and Home Based Care - A Review

Overview

This chapter generally reviewed the special edition of *American Journal of Nursing [AJNS] (September 2008) Volume No. 108* which dedicated supplement whose theme was 'State of the Science: Professional partners supporting family caregivers'. There are also some highlights on Kenya based on National Home Based Care Programme and Service Guideline (2002).

According to Gil Wayne R.N in *Nurselabs* 'A caregiver is someone who gives support and helps another person in need, such as an ailing spouse or partner, a helpless child, or an aging relative. Yet, family members who are actively caring … usually don't self-identify as a "caregiver." Delicately understanding this role could help caregivers receive the team support they need.

According to National Home Based Care Programme and Service (2002), members of the team may range from doctors, spiritual advisers, nurses to volunteers. Each member has a role to play, and an effective program will ensure that the roles are coordinated and complementary. It is therefore important to identify the core home- care team members including the volunteers, and to understand the requirements of the various care providers and the linkages among them.

In general, home based care involves about 4 components: *Clinical care* which is the therapy, medications, ongoing investigations and follow-up; *Nursing care* which involves good hygiene, promotion of health; *Counselling and Psycho-spiritual care* to deal with anxieties and stress; *Social care* which deals with social support, enhancing good family relationships etc. The roles of home-based care, therefore, includes: Accepting the situation of the patient; Being open to the care giver in order to encourage them to share their worries about the patient; Help with resource mobilization; Where possible encourage the patient to write a will.

This chapter, however, hopes to deal mainly with the caregiver, in this context the lay care providers. While this author believes that there were better and more comprehensive materials on this subject where the readers would be referred to, the importance of being able to search, utilize and disseminate evidence has been a key focus in the last five chapters of this book, this one being the sixth. This author believes EBP would take the quality of our health care a notch higher.

Began by looking for special supplements and reviews dedicated to this topic. The Medical subheadings - MeSH key search words were: (lay caregivers) OR (lay care providers) AND (home care) OR (home-based care). Delimiters included: long-term care, nursing home, home nursing, and geriatrics care. Excluded also were: self-care, nursing care at home.

Even though caretaking was a salient issue, it was not in the national agenda yet

thousands of people were lay caretaking in Kenya. In other words, it is a critical health sector that possibly does not employ but deploys. Concerning HIV/AIDS and home-based care in Kenya, there appeared to be some bias, with all the effort geared towards this area over the years, there was still no formal community home-based care in Kenya as such. Why has it not been possible? The few programs that came to be were purely donor funded just like the researches and the treatment that go with them. Few if any would have any chance whatsoever of self-sustenance without outside help.

The good African values of caring was one of the best element of our culture. But, much like other areas of society many people felt they were not being appreciated in the role of home/lay caregiving. Lay care had become a vital component of Kenya's health system, but not many people wanted to talk about it or suggest how best to run it. How we can fund it had been a no-go zone. Home care issues rarely ever came up in many policy forums. When you think about the number people who were being impacted by the lack of resources in this area, we are greatly underserving a critical segment of health care that serves the population who need help desperately.

In many parts of sub-Saharan Africa, children served as the primary caregivers for parents living with AIDS providing invaluable nursing and palliative care (Skovodl, 2011) then there are old women as caregivers, orphan carers and many other types of lay care providers (Community home-based care Action Research in Kenya, 2001, Juma *et al.,* 2004).

14.0 Introduction

Caregivers were defined according to Center for Disease Control (CDC) guidelines on isolation (Siegel *et al.,* 2007) as all persons who were not employees of an organization, were not paid, and provided or assisted in providing healthcare to a patient (e.g., family member, friend) and acquire technical training as needed based on the tasks that must be performed.

The household is a focal point for health production. It engages in a range of activities such as home hygiene, sanitation, home diagnosis and remedies (Obrist, 2006). Further, households also made use of externally available technologies, information, and skills (e.g. use of preventive and curative health). Make a financial investment in health such as home improvements, lifestyle and health insurance etc.

Caregivers perform tasks that range from coordinating care and assisting with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to administering medications, providing emotional support, and serving as liaisons and translators(Raphael & Cornwell, 2008). More than three-quarters of adults who lived in the community and need long-term care depended on family and friends as their only source of assistance with activities of daily living – ADL (such as bathing, dressing, and eating) or instrumental activities of daily living- IADL (such as transportation and managing finances) (Kelly *et al.,* 2008).

Caregivers also help to connect the components of fragmented and disjointed intersection/transitions of the formal and informal care systems, between formal and informal care systems by fostering communication between patients and providers about symptoms, concerns, and recommended courses of action, especially for patients who receive care in multiple settings (Raphael & Cornwell, 2008).

In Chapter 6 touched on lay care-takers in Kenyan hospitals who ‘volunteer' their time

and effort, kind of taking over the health provider's role in the hospital. This is an area that requires some research from local angles. For example, would caregiving in the hospital context be the same as that at home? This chapter is generally about caregiving at home. (See **Care givers** below).

Care givers

Were they somehow filling up for the shortage of staff in some of our public hospitals? It could be that the withholding of or failure to carry out all necessary nursing measures due to lack of nursing resources such as time, staffing or skill mix had necessitated lay care givers to step in. It had been observed that in some instances lay care givers were doing some element of 'total care' inside some public hospitals. What standard of care do lay care-takers give? Is it a product of clinical decision making and clinical judgment that leads to the need to have them? Much as there might be a common connotation of lay care takers in some cultures, why must we expect it? Has this been taken too far? Is the patient abandoned 'missing care' if and when he had no caretaker, *huyu hana mtu* in Swahili for 'this one has no caretaker, or 'is alone'. Another neighbouring caretaker observed 'It was not unusual that such unfortunate patients remained for days on end in the same clothes they came in. Whether they soiled or wet them them, they were not removed'.

Seems to me that negative patient outcomes e.g. falls, pressure ulcers, nosocomial infections, near-misses and generally low-quality care was likely without these care givers. Those who need proper care need someone to take care of them.

One lady said 'proper care means skin care, hygiene, feeding etc. We are the ones who give this not the nurses; she added this concerning the fate of being left unattended *ukienda utamkuta vile ulimuacha* Swahili for *'in case the caregiver was to be away the patient might be unattended during the stretch'*. Thus would it be excusable if he were unkempt or even neglected while in hospital by …Who? Interestingly, some of the admission criteria (emphasis mine) questions common in Kenya's public hospitals today were: *Mtakaa na nani? Mko na nani? Nani atamchunga?* In Swahili for *'Who is staying in/ rooming with you? Whose custody?'*

What do some of those concerned think? 'As nursing advanced some procedures were left to the caretakers'. This was an answer given to this author by one correspondent who did not blink an eye as she said so. In African context not blinking an eye means saying or doing something unashamedly, without feeling guilty conscious.

14.1 Terminologies

Schumacher and colleagues (2000) described *family caregiving skill* as the "ability to engage effectively and smoothly" in nine care processes requiring psychomotor, cognitive, and psychological skills.

Caregiving denotes care that is provided by a family member or friend rather than by a professional who is reimbursed for services (Schulz *et al.,* 2008). While Farran (2007) and colleagues defined a *caregiver skill* as "something that caregivers do" using "goal-directed behaviours based on knowledge, experience, or personality style."

According to WHO in Community home-based care Action Research in Kenya (2001), the actual care giving included direct physical and emotional care, management of symptoms and medical regimens, as well as the performance of surrogate roles by the caregiver. There are many different types of family caregiver situations. One may be taking care of an aging parent or a handicapped spouse. Or perhaps caring for a child with a physical or mental illness. This chapter will try and handle the caregiving to the sick at home.

Skill was defined as "goal-directed, well-organized behaviour that is acquired through practice and performed with an economy of effort." Skill could also involve ability to access useful information, interprete it, ability to articulate issues and tell their story.

Caregiving has all the features of a chronic stress experience: It created physical and psychological strain over extended periods of time, was accompanied by high levels of unpredictability and uncontrollability, had the capacity to create secondary stress in multiple life domains such as work and family relationships, and frequently required high levels of vigilance (Schulz *et al.,* 2008). Because better treatments have extended the life spans of most patients with chronic illnesses, caregiver involvement often is required for several years (Given *et al.,* 2008).

Standard definitions of family caregiving and reliable estimates of its size and scope could provide strong evidence for the argument that family caregivers provide substantial value to the health care system. Robust estimates of the financial value of the care they provide would build a stronger body of evidence for models that, ideally, would lower costs and improve outcomes (Raphael & Cornwell, 2008).

Relatives contributing services that would cost hundreds of billions of dollars annually if they had to be purchased (Schulz, 2008). The value of family caregivers and their quantifiable effect on costs and outcomes need to be established. It was estimated that an average of 21 hours of care a week was given to adults with an ADL or IADL constraints. The estimated value of this care was about $350 billion per year (Raphael & Cornwell, 2008).

Concerning the Kenyan situation it was proposed in (NASCOP, 2002) National Home-Based Care Programme and Service Guidelines that *communities are encouraged to find ways to provide incentives to volunteer home care team members to enable them to maintain their commitment.* Policymakers need to be convinced that caregiving is a major public health issue (Schulz *et al.,* 2008). Community home-based care Action Research in Kenya, (2001) 40% of caregivers said they devoted 12 hours or a day full seven days a week activity calendar.

14.2 Lay care is a health policy issue

Census Bureau projections: Show that the population of people ages 85 and older, the fastest-growing group in the US. More people of all ages were living longer with chronic conditions such as cancer, cardiovascular disease, and diabetes while the prevalence of chronic conditions usually increased with age (Raphael & Cornwell 2008).

Increasingly, those facing chronic disease or disability preferred to age in their own homes and communities remain independent as much and for as long as possible. Older adults with mild to moderate cognitive impairment place greater emphasis on autonomy, safety, quality of care, and not being a burden and slightly less emphasis on social interactions (Whitlatch, 2008).

The demand for family caregivers (primarily from wives or daughters) will likely outpace in the future (Raphael & Cornwell, 2008). Older spouses tend to develop illnesses and disabilities at about the same time; one partner may have health problems that require a caregiver (Schulz *et al.,* 2008). The supply of such caregivers is shrinking as more

women enter the workforce, birth rates decrease (resulting in fewer children to provide care), and the geographic distance between family members grows due to rural-urban migration as well outmigration (Raphael & Cornwell, 2008).

Care giving had a gender bias component. For example in Community Home Based Care: Action Research in Kenya, (2001) out of 53 [46 females, 7 male] caregivers in the study among whom 10 was the wife, 13 the mother, 8 the daughter, 6 daughters-in-law, 4 the sister. The father, son husband was one for each category. 62% took care of someone with HIV/AIDS-related condition.

As medical Insurance payers continue to pressure providers to reduce costs associated with inpatient hospital stays and institutional care. This places additional pressure on friends and family to provide care after the formal system stops (Raphael & Cornwell 2008).

But most health policies do not acknowledge that family caregivers are an extension of the care delivery team and may need care themselves. A critical review of (NASCOP, 2002) by this author came to more or less the same observation. The home based care team seemed to end with the community health volunteers. This suggests that longer-range public policy is needed to address these challenges and spur system changes to respond to caregivers' needs and help them manage the demands placed upon them (Raphael & Cornwell 2008).

Abandon their home to care take

Grannies abandoned their home to take care of their ailing relative, a university student. The Hospital in Nakuru County had for the past two months become the new *home* of BW, 67, and her husband MG, 70. At the hospital, the two grannies had to keep a constant eye on their granddaughter. They helped her walk and sit up; they also fed and bathed her.

"This is my new home because I have to be by grand-daughter's bed to ensure that she does not fall." Meeting the hospital bill was a challenge. The elderly couple was at the mercy of well-wishers.

Their granddaughter's health challenges had affected the family's operations. They had not been able to prepare their quarter of an acre for the planting season.

[As was reported in a local daily]

A policy agenda for incorporating and supporting caregivers as part of the health care team. It should be organized around establishing the value of caregivers, establishing standards and guidelines, creating a system of accountability and incentives for providers, and finding a role for technology in helping to incorporate caregivers into the health care team and support their needs.

A team of health care providers could be taking care of a block or flats offering 'concierge care' where some patients were willing to spend more money to be able had enough time with their professional health care provider to address their concerns. This would be made easier if there were a government policy and insurance cover for home care. A token for lay care givers would be a big incentive.

The situations are varied in terms of intensity of care and dependency. For example, caring for a person with chronic illness and a disability complicates the challenge of care giving. The care giver needs support when they experience frustration, anger or loneliness. The care giver has a powerful, positive influence on the recipient's life.

Regardless of the particular circumstances, this is a challenging new role. New responsibilities and probably was never anticipated. Individuals suddenly "become" caregivers and are provided with little guidance before assuming care responsibilities, yet they are responsible for increasingly complex tasks, including not only clinical tasks, such as wound care but also symptom recognition and management. Poorly planned hospital discharge is associated with adverse events, which occurred in nearly one in five patients and could precipitate readmission (Raphael & Cornwell 2008).

There was a lack of communication and a high rate of misunderstanding of diagnosis, prognosis, care decision making, discharge planning, and home care follow-up as reported by Whitlatch (2008). Communication and decision making occurred within the patient-family- caregiver-practitioner care triad. Several studies about this can be accessed(http://links.lww.com/A504).)

14.3 The transition period

According to Nguyen *at al.,* (2016) in a study conducted between 2009 and 2010 at six hospitals in North Texas USA, entitled *Vital signs are still vital.* They reported that 1 in 5 hospital patients were discharged with unstable vital signs. This was a likely cause of deaths, readmissions. Within 24 hours of discharge such as anomalies in heart and breathing rate, oxygen saturation, blood pressure and temperature were still there or had developed since discharge. Yet these patients would have been discharged home or post-acute care facility.

Poor "handoff" of these patients and their family caregivers from hospital to home had been linked to adverse events, low satisfaction with care, and high re-hospitalization rates (Naylor & Keating 2008). Further added that poor communication, incomplete transfer of information, inadequate education of older adults and their family caregivers, limited access to essential services, and the absence of a single point person to ensure continuity of care all contributed to uncertainties of homecare (See **In and out below**)

Nguyen *et al.,* (2016) recommended that going forward; there were a number of simple steps hospital leaders could take to safeguard against such oversights, according to the researchers. They suggested that hospitals should:

- Add vital sign criteria to discharge guidelines
- Only discharge any patient who has one abnormal vital sign with extreme caution
- Keep patients who have two or more abnormal vital signs in the hospital
- Conduct a thorough follow up on discharges
- Consider alternatives to post-acute care facilities

In the Kenya's public health settings we do not have post-acute care facilities, so may be the last recommendation. These post-acute care facilities can be something we can

actually endeavor to have at least for the fairer patients even as we decide what to do with the unstable discharges. The concept, however, is strange to most people as they might not get the difference between this and the hospital.

Level of health literacy (carer's and recipients') issues and cultural differences exacerbate the problem. Consequently, family caregivers consistently rated their level of engagement in decision making about discharge plans and the quality of their preparation for the next stage of care as poor (Naylor & Keating 2008).

Caregivers' distinctive needs during transitions in care, an educational program that emphasized engaging the patient and caregiver in the discharge planning process. Watching a videotape on post-discharge care management, and receiving information on accessing community services (Naylor & Keating 2008) and where possible liaise or handed over to proven community-based transitional care service (Kelly *et al* ., 2008).

When they were assessed two weeks post-discharge, caregivers in the intervention group were more satisfied with their roles than peers in the control group were. In an ideal situation, coaching should begin in the hospital and continued for 30 days after discharge (Naylor & Keating 2008).

14.4 Hospice model: what can be borrowed?

Hospice care could provide a model for formally incorporating family caregivers. In hospice care, family caregivers are considered care recipients as well as part of the health care team. They receive counselling throughout the period of patient care along with training to manage and recognize symptoms to ensure good palliative care.

Home-based hospice care models support the family caregiver to enable the patient to remain at home. This includes preparing the caregiver from the start of care for dealing with practical matters-such as how to position a care recipient in bed, transfer her or him between bed and commode, and provide care to maintain comfort-and reinforcing that preparation during every nursing visit to the home.

It also included preparing the caregiver for what to expect when a person was dying. The process reduces staff productivity because more time is required per encounter. The resource-intensive hospice care model could be difficult to follow (Raphael & Cornwell, 2008).

14.5 Home care model

Program of All-Inclusive Care for the Elderly (PACE) is a state-financed approach that covered in-home supportive services (Chin, 2008). *On Lok Senior Health Services* in San Francisco was the prototype for PACE. On Lok originated in the early 1970s as a way of filling the gap in long-term care options for older adults especially of Filipino and Chinese immigrants.

PACE served 15,000 people in 22 states and integrated social and medical services through a combination of adult day health care and home care. To be eligible participants had to be aged 55 or older (the average age was 80 years). Although they would have met the nursing home admission criteria, PACE participants were able to live safely in the community (Chin, 2008).

In the PACE model, an interdisciplinary team provided both health care and social services. The interdisciplinary team at each PACE center included at least one physician, nurse, social worker, dietician, occupational therapist, physical therapist, and recreational therapist.

Complementing these professionals are home care workers and other ancillary personnel, such as drivers (Chin, 2008). According to Schulz *et al* (2008), nurses' role in home health care has expanded from being primary caregivers to teaching and assisting family members to provide care. Similarly, social workers now play a critical role in providing advice and support to caregivers.

Components of PACE included primary care, specialty care, adult day care, home care, hospital care, nursing-home care, medication oversight, and transportation to medical appointments. The primary site of delivery for many of the services is an adult day health care centre.

According to Chin, (2008) the ultimate test of care coordination and care delivery systems was when a patient was discharged from the hospital on a Friday at 5:00 PM *before a long weekend* (emphasis mine). Not only did the PACE model pass this test, it recognized the needs of both the patient and caregiver and the family unit.

From the Program of All-Inclusive Care for the Elderly (PACE), we learn that:

-The health care delivery and financing systems needed to be redesigned to help older adults with multiple clinical, functional, and social issues best maintain their well-being with appropriate use of preventive, acute, and rehabilitative services.

-Coordinated, simplified, and comprehensive care obtained through a "health care home" was both possible and cost-effective for helping older adults and their family caregivers manage health conditions at home, including acute episodes, and improve their quality of life.

-Culturally appropriate and effective care was best achieved with a community base rather than the typical institutional focus. Other home-based care models include *Hospital at Home* (http://www.hospitalathome.org)

14.5 Mental health of the caregiver

Mens sana in corpore sano – Latin for a sound mind in a healthy body. Caring for an ill parent, spouse, partner or friend involves much more than physical and emotional support. Caregiving is a life-changing experience that can be both gratifying and stressful (TCARE).

Researchers have known for some time that individuals in supportive social relationships were happier and healthier and lived longer than those who were socially isolated. Other findings even suggested that supporting or helping others may be just as beneficial to health as receiving support (Schulz *et al*., 2008).

Moving into a demanding caregiving role-providing assistance with basic activities of daily living (ADLs) for 20 hours or more per week-resulted in increased depression and psychological distress, impaired self-care, and poorer self-reported health (Schulz *et al*.,

2008). While improved patient functioning was associated with reductions in caregiver distress. The death of the care recipient has been found to reduce caregiver depression, and caregivers are often able to return to normal levels of functioning within a year.

A practice that could be benchmarked would be the use of tailored websites like caringbridge.com or aetna.com. You might even be attended to earlier if one was a patient.

In and out

When I did my mental health clinical rotations couple of years ago, it was surprising the rate of turnovers at the facility. I was amazed at the discharge rate in a day or two we were off duty, where had all those patients gone? I wondered if there were any follow-ups. Some of the patients I had talked to just a day or so before had some horrifying things to say, clearly making them unsafe to themselves and others. I wondered if the limited days of admission was an adequate fix for them. However, they were discharged after only a couple of days to make beds for others. These people fall through the cracks and might carry out deadly plans.

(Shared by a student nurse)

The effects on the caregiver's health were moderated by individual differences in resources and vulnerabilities, such as socioeconomic status, prior health status, and level of social support (Schulz *et al*., 2008).

Evidence had been found of impaired health behaviours, such as neglecting their own health care appointments and eating a poor-quality diet among caregivers who provide assistance with basic activities of daily living (ADLs) like toileting and eating, reduce their time for leisure and social activities (Schulz *et al*., 2008; Whitlatch, 2008). They also found that care recipients with dementia typically required more supervision were less likely to express gratitude for the help they received, and are more likely to be depressed.

Given *et al*., (2008) concurred that caregiving was more complex and the family's distress more acute if the patient has impaired cognition or neuropsychological symptoms. Caregivers also needed to know how to deal with difficult situations like anger, depression, rehabilitation, disruptive behaviours, just as much as they needed to know how to handle incontinence (Given *et al.,* 2008).

Providing help that failed to enhance the quality of the patient's life may lead to frustration, resignation, and negative health effects for the caregiver. The level of patient suffering may contribute just as much to a health decline in the caregiver's health (Schulz *et al*., 2008).

Community home-based care Action Research in Kenya (2001) in the case of child caregivers the lost opportunities like missing or dropping out of school, forgone age-appropriate activities like missing out on child play and disillusionment were a reality. (See **Times of need** below):

But it was likely that providing help that significantly addressed the needs and desires of a patient was uplifting to the caregiver and contributed to positive health effects. *Kenya Basic Needs* a nongovernmental organization operating in various parts of Kenya is actively involved in developing mental health policy and legislation to influence the

development of mental health services at the national level. It draws on its young advocates and user groups to inform and guide this engagement with policy makers.

Times of need

CaringBridge transforms your personal connections into support when you need it most. Down deep, more than anything else, people want to stay connected. Especially during a health event. By creating a free ads-free CaringBridge website, people in a time of need can share updates, photos, and videos, connecting with friends and family who care and want to help. With words of encouragement: Feel the difference a community can make. Family and friends can provide messages of love and hope through a CaringBridge Guestbook. See the following two testimonies: "I think my favourite part of using CaringBridge is reading the encouraging notes people leave.",

"There have been very scary times - on the way to the ER or right after I heard bad news that lef me heartbroken -when I turned to my CaringBridge Journal first. I knew that putting it out there, the support would come flooding in when we most needed it. It was the easiest way for us to share news fast." http://www.caringbridge.org/(http://blog.caringbridge.org/being-great-patient-advocate/

As of June 2015, 78,207 people including those affected by mental illnesses, their carers and family members had been supported through this program. King'ori, program manager Basic Needs Kenya had this to say:

> …The 15,292 affected people we have reached is a small fraction in the backdrop of hundreds and thousands living in rural and urban neighbourhoods in Kenya, on the streets, chained in their homes, in schools, workplaces with no access to treatment, social and emotional support to recover and means of livelihoods to sustain them once they stabilise (http://www.basicneeds.org/where-we-work/kenya/).
>
> Another such program is Larche´, an initiative of Catholic Diocese of Nyahururu that worked together with families of mentally handicapped children in home care. Sometimes solution was by becoming the solution ourselves, as seen below:
>
> 'The doctor said my baby had autism but that was all. Nobody explains it; nobody tells you what autism can do to your child or what to do. So you go home and start finding out things on your own. So you start consulting *Dr. Google*. I didn't know what milestones were and beyond the diagnosis what it meant. During the 2nd pregnancy, I had like 50 ultra sounds to monitor the baby in uterus who ended up with Down's syndrome.
>
> I was devastated. Since I could not access support from others, I decided to start a support group myself. Almost everything changed; I got to meet others who were in similar difficulties. Together we have been able to forge ahead and I find lots of fulfilment in what I do'. They came up with a league of mums who loved, supported and raised children with special needs.
>
> One of them CMM had started a home therapy for children with cerebral palsy. One of them suggested that there ought to be support groups for siblings of children with special needs, who find themselves in this relationship of caretaking. [These respondents were participating in a discussion 'Mother's Love' at Victoria's Lounge, NTV on Mother's Day - 12th May 2017].

14.6 The care giving knowhow

Caregivers needed certain knowledge and skills both to provide the best possible care and to protect their own well-being. According to NASCOP (2002), they needed facts about HIV/AIDS; nursing care procedures; drug compliance; counselling; death and dying; infection control; legal rights etc. It was a whole curriculum so to speak.

Patients with chronic illnesses and multiple comorbid conditions usually have intricate treatment protocols that required a lot of caregiver involvement, further complicating an already difficult care (Given *et al.,* 2008). Their feelings of uncertainty contributed to their distress.

Many family caregivers reported they didn't have the necessary skills and knowledge to provide sustained care for a person with a chronic illness, so they lacked confidence and felt unprepared. Caregivers said they received little guidance from providers, that they didn't know how to assume the caregiver role, that they weren't familiar with the type and amount of care needed, and that they didn't know how to access and utilize resources (Given *et al.,* 2008).

The requisite caregiver skills described by Schumacher and colleagues (2000) included monitoring, interpreting, making decisions, taking action, adjusting to changing needs, comforting with hands-on care (direct care), accessing resources, working with the ill person, and negotiating the health care system. Some caregivers were able to carry out caregiving tasks better than others because of their knowledge, experience, level of engagement especially for skills such as monitoring and interpreting require complex reasoning.

The demands of providing care depended on factors such as the patient's personality; the type or stage of illness; and the caregivers' physical, cognitive, social, organizational, and psychological knowledge and skills (Given *et al.,* 2008).

Plans of care should be based on a thorough assessment of both recipient need and caregiver capacity. Assess care demands while evaluating the caregiver's availability, capacity, knowledge, skills, competing family roles, and resources. The predictability and routine nature of the care, as well as its duration (weeks or months) and quantity (daily hours of care), must be considered when implementing therapeutic plans of care with the family (Given *et al.,* 2008).

Whitlatch (2008) described one approach referred to as *ANSWERS* (Acquiring New Skills While Enhancing Remaining Strengths), which trains care partners in how to manage specific issues such as memory loss, communication, staying active, and recognizing emotions. This enables caregivers to receive guidance, counselling, and direction from health clinicians and to rehearse what they learned so they can take appropriate action with their family members.

As cognitive loss becomes more pronounced, the person loses the ability to answer factual questions, such as those about age or birth date, but can still state preferences, such as a favourite colour or food (Whitlatch, 2008).

Family members caring for someone with cognitive impairment might be able to understand their relative's preferences as long as care values have been discussed early in the course of the disease. It was important to acknowledge the potential and ability of those with cognitive impairment to be involved in discussions about their care for as long as possible. Even those in coma still retained their hearing senses. Understand the impact of patient autonomy in family decision making.

Care preferences often changed according to circumstances, which made it difficult to anticipate needs and preferences (Whitlatch, 2008). Carpenter and colleagues (2006) reported that adult children were fairly accurate in predicting their parents' overall preferences for care, but overestimated parental desire for predictability, routine, and control while underestimating their desire for enrichment and personal growth.

Families often must balance conflicting preferences for care. For example, a woman who is caring for her father might be forced to reconcile his desire that only *she* provide assistance with the fact that she desperately needs help in caring for him (Given *et al.,* 2008).

It's often very challenging and stressful for a family to separate the needs, preferences, and best interests of the chronically ill person from those of family members. As time passes and caregivers adapt to their altered roles at home or the long-term care facility, they are more likely to adjust well at work and experience improved emotional well-being (Whitlatch, 2008).

Caregivers need to perform complex medical tasks, supervise patients, make decisions, solve problems, provide emotional support and comfort, and coordinate care. Using these skills, caregivers administer medications, plan and provide meals, handle medical equipment, and provide direct care such as wound care and lifting and turning. Caregivers also provide custodial care, transportation, and advocacy.

Some tasks were merely time-consuming; others were difficult. Family caregivers also typically managed the household. To improve function and safety for the patient, caregivers may need to modify the environment and acquire equipment and assistive devices (Given *et al.,* 2008) Community Home Based Care: Action Research in Kenya (2001) found that lack of protective devices was a major problem while giving physical care. There was also limited knowhow on universal precautions such as hand-washing and disposal of waste including the principle of reducing, recycling and re-use of waste.

Caregivers also needed to learn to monitor patients for new signs and symptoms, adverse events, and positive responses to treatment. Caregivers also needed to learn to monitor patients for new signs and symptoms, adverse events, and positive responses to treatment. As symptoms change, caregivers should communicate directly with health care providers (Given *et al.,* 2008).

Changes in the severity of symptoms or the appearance of new symptoms as the disease progresses could heighten the caregiver's perception of loss of control. This could cause distress and uncertainty because worsening or increasing symptoms might affect physical function and increase the demand for care (Given *et al.,* 2008).

Demands on caregivers escalated as treatment plans changed, the disease progressed, the patient's functional or cognitive capacity deteriorated, or the patient neared the end of life. Nurses and social workers should reassess caregivers' capabilities when such changes occur (Given *et al.,* 2008).

It was unfortunate that corruption cases involving the same cadres in connection with the waiving process were rampant in some hospitals. Some clients had fallen prey to the same people who could have helped them.

Preparation for the role improves families' ability to better manage their everyday care responsibilities, reduce their own burdens and health risks, and promote a better quality of life for both the older adults receiving care and the family members providing it.

Improve professionals' ability to assess the needs of family, friend, and neighbour caregivers; provide caregivers with the information and skills needed to deliver care; and lead in the development of family-friendly policies, practices, and environments across health care settings (Kelly, 2008). Sending a link to the material on 'Caregiving' on the website can be very helpful. I found HELPGUIDE.ORG an invaluable resource (See **New to caregiving** below):

> **New to caregiving**
>
> Learn as much as you can about your family member's illness or disability and about how to be a caregiver. The more you know, the less anxiety you'll feel about your new role and the more effective you'll be.
>
> Seek out, other caregivers. It helps to know you're not alone. It's comforting to give and receive support from others who understand what you're going through.
>
> Trust your instincts. Remember, you know your family member best. Don't ignore what doctors and specialists tell you, but listen to your gut, too.
>
> Encourage your loved one's independence. Caregiving does not mean doing everything for your loved one. Be open to technologies and strategies that allow your family member to be as independent as possible.
>
> Know your limits. Be realistic about how much of your time and yourself you can give. Set clear limits, and communicate those limits to doctors, family members, and other people involved.
>
> (Courtesy of HELPGUIDE.ORG) http://www.helpguide.org/articles/caregiving/caregiving-support-and-help.htm

Skills based on knowledge and could be classified as psychomotor (such as catheter or wound care), cognitive (such as monitoring, decision-making, and problem-solving), or psychological (such as offering emotional support).

One of the most important skills was the ability to communicate effectively with health care providers (Given *et al.,* 2008). The earlier and more accurately a caregiver can identify various symptoms, the earlier the caregiver can get the patient to a physician to avert a true emergency. Reduce re-hospitalization rate and increase patient and caregiver satisfaction (Raphael & Cornwell, 2008).

Competing demands such as work, travel, and child care should alert professionals to the risk of overload, strain, or an inability to continue to provide care. Health professionals

and family caregivers should collaborate to ensure optimal care is given (Given et al., 2008).

Caregivers need interventions to help manage patient symptoms. Reducing uncertainty about care relieves their stress. If they know to call a physician for a fever of 38.2 [degrees] Celsius, for example, they can make decisions and worry less. Studies demonstrate that these interventions can help caregivers set priorities, solve problems, and make decisions (Given *et al.,* 2008).

Cognitive behavioural management approaches were the most common interventions used with caregivers. They focused on cognitive stimulation, supervision, monitoring, medication administration, communication, memory enhancement, and problem-solving. There was a need for booster sessions to learn additional knowledge and skills (Given *et al.,* 2008).

Caregivers needed to acquire knowledge for goal-directed behaviours and for priority-setting, decision-making, and problem-solving skills. However, most educational programs are not evidence based. Specific and tailored information, such as books and videos, helps support caregivers and reduce their uncertainty (Given *et al.,* 2008).

We can conclude from the evidence raised by Givens *et al* (2008) that family caregivers were an important national health care resource and that formal interventions for caregivers are needed to achieve optimal clinical outcomes. Program planners, providers, and policymakers must work together to provide the support services needed by family caregivers. There was still a lot of ground needed to translate knowledge and skills into care by establishing which best practices were.

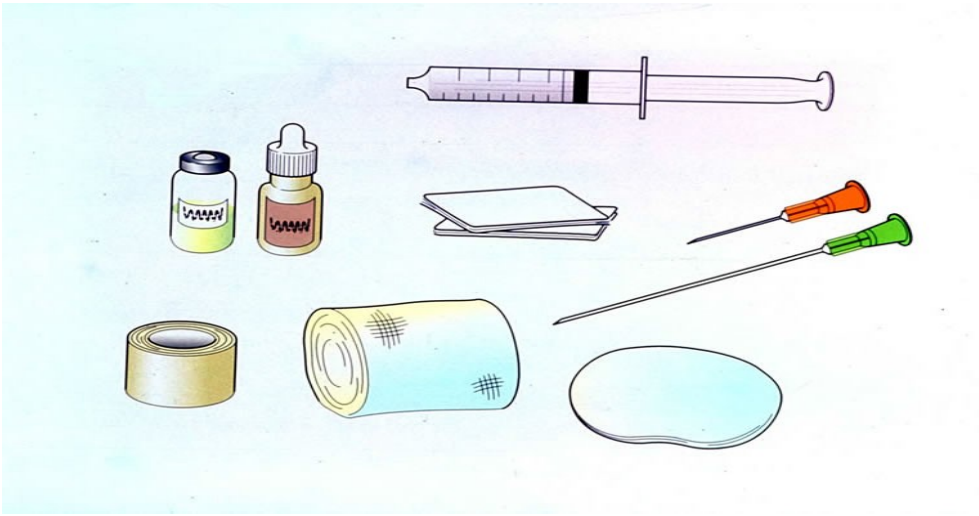
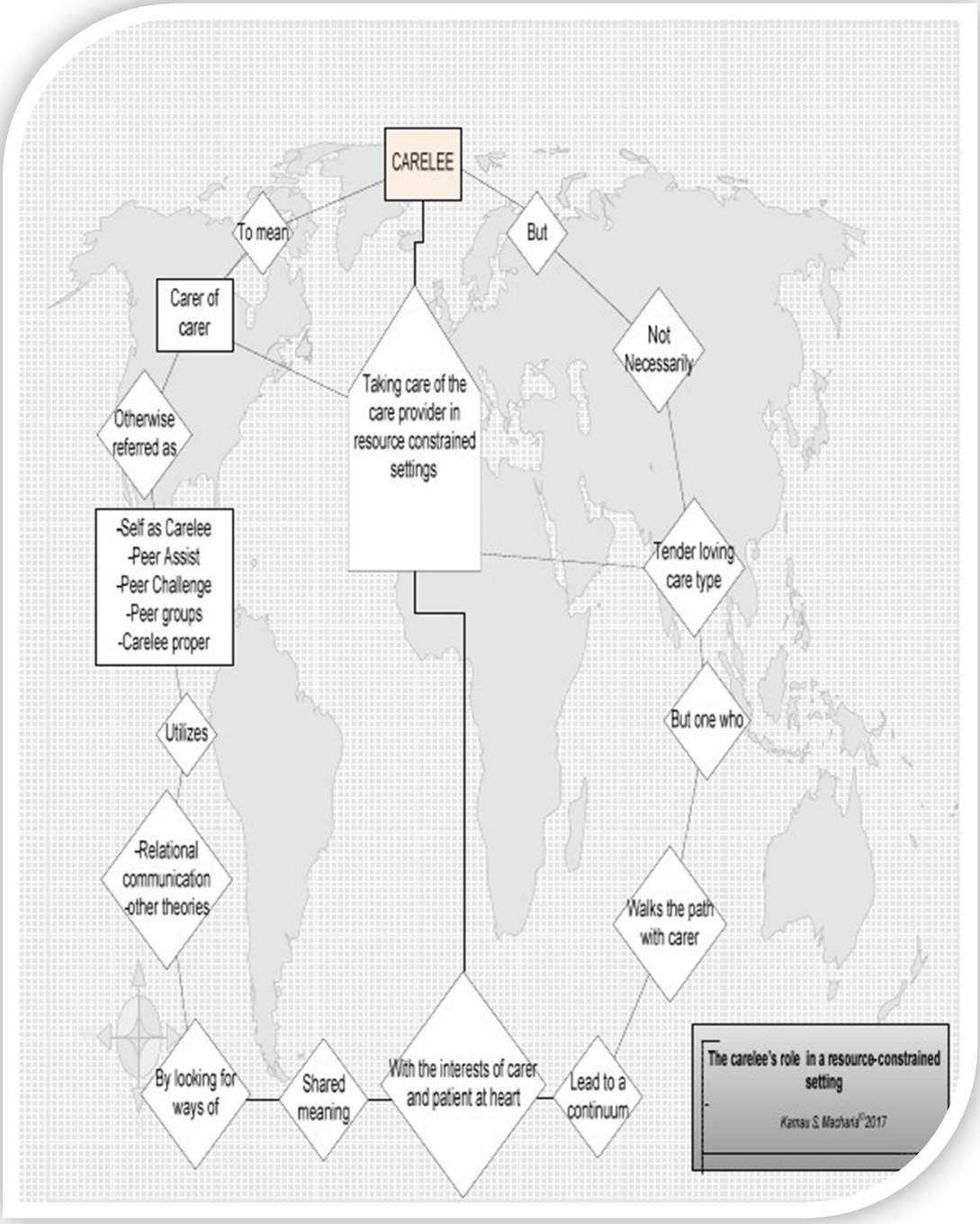


Fig: Caretaking might involve ursurping a number of 'medical' skills by the laycare provider



Also see Carelee on Wikipedia (user draft)
https://en.wikipedia.org/wiki/User_talk%3ASymomash?oldid=736733792.

14.7 Caring for the carers

According to Raphael & Cornwell, (2008), assessing caregiver preparedness and providing necessary training should be developed, followed by a means for measuring performance and holding providers accountable for assessing and preparing caregivers. Practitioners must consider not only how the caregiver can help the care recipient, but also how the service provider must help the family.

The success of most care plans - from hospital discharge to home often fell to the family caregiver. If the caregiver becomes ill or could no longer cope with caregiving tasks, the care recipient suffered (Friss, 2008). The study added that family caregivers needed their own care plan in order to provide better care and to maintain their own well-being.

14.8.1 Tailored Care Giver Assessment and Referral *(Utilizing the Caregiver Identity Theory)*

The Caregiver Identity Theory articulated by Montgomery and colleagues is the theoretical underpinning for the TCARE (Tailored Care Giver Assessment and Referral) process. Dr. Rhonda Montgomery is an internationally renowned researcher in the field of caregiving and Professor Emerita at the University of Wisconsin-Milwaukee.

The theory was specifically designed to support family members who are providing care for relatives who need assistance due to illness or disabilities. This theory describes caregiving as a systematic process of identity change in which the initial familial relationship (such as mother-daughter) gives way to a relationship characterized by caregiving.

This theory describes caregiving as a systematic process of identity change in which the initial familial relationship (such as mother-daughter) gives way to a relationship characterized by caregiving.

TCARE enables consistent, accurate screening and assessment of caregiver needs; uses scientifically-based decision algorithms to target services to specific identified needs; and fosters informed client choice and person-centred care. It also offers training component for professionals who work with family caregivers. (See links to resources below).

Changes in the caregiving experience require corresponding changes in caregiving behaviours and therefore changes in the services caregivers need as follows:

> *First,* caregiver stress has been shown to be the most direct measure of the caregiving experience. Caregiver stress is multidimensional and influenced by a wide range of factors, such as a change in the relationship between the caregiver and care recipient or a change in the caregiver's physical health.
>
> *Second,* the caregiver identity theory takes into account the great diversity among caregivers. They vary in the type and number of tasks they undertake, the length of time they serve as caregivers, the costs they incur, and the benefits they perceive in their caregiving role. The theory recognizes that the experience of caregiving is determined not only by the care recipient's disease process and level of disability but also by factors that are grounded in family roles and culture.

Third, the caregiver identity theory provides insights about the great variation in the services that caregivers use. Essentially, caregivers will not use services that they don't perceive having a need for. The perception of need was influenced by characteristics of the caregiver, the care recipient, and the provider. This theory helps explain why some caregiver interventions, such as respite services, are not uniformly beneficial. Concise Oxford English Dictionary defines respite as a short period of rest or relief from something unpleasant.

The TCARE was able to predict when to involve the caregiver and caregiver support groups, being referred to the services that are most pertinent to their needs so that they use services or tap into them before it was too late in the care process to be beneficial.

The Caregiver Identity Theory incorporates assessment tools and decision maps:

Assessment tool. The goal was to create a tool that was clear, specific, reasonably short, easy to use, and helpful in creating effective care plans. Montgomery et al., *(*2008) developed a registry of caregivers in an area. Each one completed a series of four questionnaires designed to identify caregiver burden. From the responses, develop an assessment tool consisting of 32 questions that gather information about the caregiver's activities, obligations, resources, and stress and the care recipient's physical and mental conditions.

Decision maps. They are a central feature of the TCARE protocol. They are a set of maps, or algorithms, that guide care managers through a decision process. The maps help them use the information gleaned from the assessment tool to identify for each caregiver the most appropriate intervention goals and strategies for reaching the goals. Decision consistent with the caregiver stress and the effects of various types of support services are mapped.

Five of the six decision maps (A to F) Available: (http://links.lww.com/A503) are designed to address the specific needs of caregivers who have different combinations of scores on the three measures of caregiver burden (relationship, objective, stress) and who among them would likely consider placing (referring) the care recipient to an alternative care setting (e.g. long term care centre, nursing home etc.) in the near future. Making the transition out of the caregiving role because the patient improves, enters an institution, or dies left a big impact on the caregiver (Shultz et al 2008).

The three measures of caregiver burden included:

* *Relationship burden*, or stress in the relationship between the caregiver and care recipient.

* *Objective burden*, or the perception that caregiving responsibilities infringe upon other aspects of the caregiver's life, such as privacy, other relationships, work obligations, and opportunities for leisure activities.

* *Stress burden* or generalized anxiety or strain stemming from the caregiving experience.

The sixth map (F) is a supplemental algorithm referenced in some of the other maps to guide care managers in making appropriate care plan goals based on all the assessment data collected.

Once standards and guidelines are established, providers should be held accountable for educating, training, and supporting caregivers as partners in care (Raphael & Cornwell, 2008). Incentives for involving caregivers, and disincentives for not involving them, would need to be substantial enough to motivate *providers* to do so.

Sources from their website August 2016 http://uwm.edu/tcare/ accessed on 4th indicated that TCARE® had been implemented in 17 States in the US, by over 275 state and local social service organizations and 10 military installations. TCARE had improved the lives of 20,000+ caregivers.

It had been tested and proven through randomized and longitudinal studies to reduce caregiver stress and clinical depression and increase the positive feelings caregivers have about caregiving. Longitudinal studies had also linked TCARE with a delay of out-of-home placement of the care recipients. TCARE is a model that we in Kenya can customize, to make it tailor made for the local use.

14.9 Way forward

We need to draw feedback from hard-won insights of caregivers, the challenges of day-to-day care, and the creative relevant solutions they have found to complicated problems. A down to earth policy or law was needed to support lay care providers: that addresses the financial status of the family and the community who often did not have money to buy drugs and other materials.

Who were emotionally drained, need someone to hand over care to etc. Whose economically productive time had otherwise been taken up by the caring role. *The most precious treasure of all that one exhausts is time* - Alexander the Great. When we give someone our time, we actually give a portion of our life that we can never take back. This was a stark reality for many a care giver.

The challenge is to develop curricula for professional education and training in nursing and social work, as well as other health professions, to prepare practitioners to implement caregiver assessment as a routine part of practice across all settings (Friss, 2008). Producing a cadre of nurses and social workers who embrace a patient *and* family-centred care perspective (Kelly *et al.,* 2008).

Home care can bridge the geographic distance between providers, caregivers, and patients, such as those in rural areas. If technology such as geographical information systems were incorporated to clinical decision support, telemedicine etc. they would provide regular and *reliable* monitoring of safety, symptoms, and treatment adherence, thus improving outcomes.

For Kenya, there was a need to implement a community-based home care policy integrated and scaled up into the existing health care system. This was because in the past though community health workers (CHWs) and volunteers (CHV's), as well as caregivers, were expected to be supported by the health system, they were not necessarily part of its

organization. Yet in low-resource settings, community health workers were frontline providers who shouldered the health service delivery burden. They serve as connectors of communities to formal health systems and as an entry point in community entry/diagnosis.

By directly visiting households, CHWs and CHVs can increase access to care for groups who are particularly difficult to reach, such as secluded women, the extremely poor, or the lowest classes of society.

CHVs regularly checked the living conditions of the community members and advised them on how these conditions can be made healthier. They also identified individuals who were unwell and referred them to health facilities. They participated in public education in health issues.

In addition, they participated in immunization programs, distributed insecticide-treated mosquito nets. Something so key in their role working with partners in health care the CHVs participated in the door to door counselling and testing campaign aimed at making people aware of their HIV status. At times community health workers (CHWs) and volunteers (CHV's) were not in the communities as per protocol, but often ended up staffing under-served health facilities, often working unsupervised.

Another category of CHVs consisted of traditional birth attendants. They assisted expectant mothers during delivery, this was especially important in many African communities because many women preferred to deliver at home.

Some incentives e.g. making available free kits for home care, infusion therapy, demonstrations, regular home visits for follow-up by medical social workers, nurses etc., medical insurance cover, training opportunities for caregivers, emotional support and guidance (Community home-based care Action Research in Kenya, 2001). Access health information via a Web portal would play a critical role.

The usefulness of such portals to patients is well known but these benefits apply equally to family caregivers. Some portals offer process-related functions, such as the ability to view and modify appointment schedules, request prescription refills, and communicate with a clinician about non-emergent concerns (Raphael & Cornwell, 2008).

With the right help and support, one can be an effective, loving caregiver without having to sacrifice themselves in the process. One could choose to have a trained home care giver like what used to be offered by Rafa Home Patient Care Center located at Shabab, Nakuru. It claimed to offer a 3 and ½ months certificate course in patient, disability, aged care. Its founder David Maina, an Occupational Therapist observed that 'the demand for private care givers was on the rise as nurses in Kenya took to the street in protest over allowances owed to them' in mid 2017.

To rise above the tide just change the name of the course, make sure there is no word like patient attendant or nurse aid etc and you are good to go. So that is what many of them did. Metropolitan Hospital in Eastlands, Nairobi also trains healthcare assistants.

This would become his undoing because no sooner than had he released this self assured video clip on TV than the nursing associations and Nursing Council of Kenya (NCK) officials descended on the institute and ordered it closed, but it soon resurfaced, at least on social media that was the case. *Nurse at your doorstep* was another home nursing outfit whose social media profile @doorstepnurse.com indicated it was located in Nakuru.

Nanyuki Cottage Hospital in Laikipia County was a non profit making level 4 60 beds hospital. Apart from the usual hospital services it also doubled up as: sheltered housing, frail care center taking care of patients with special needs in their own words 'a home away from home' medical tourism. The special center fee beginning from as low as Ksh 3500 (US$ 35) per month. Some of these clients had been in the facility for over five years. It provided for Laikipia Association of People with Ewpilepsy (LAWE).

This author role is in interrogating health systems, to offer what would perhaps be a balanced view. Either way it was difficult to defend either position. Chapters 17 and 18 are dedicated to the future of nursing and the role of nursing education respectfully while chapters 8 to 14 deal exclusively with evidence based (nursing) care.

While nurses' recruitment outfits for overseas market thrived, few if any nursing agencies existed to meet the domestic market, including home based care. The market share existed. Some Kenyans were willing to hire someone to take care of their loved ones at home, someone with some basic skills.

This had led to some 'aides' affording to set up as self employed, complete with business cards and social media pages, rounding up a reasonable clientele. Some were able to combine physical therapy, massage and good customer care with what they did. On the other hand an official of Nursing Association of Kenya (NNAK) observed that 'a quick and sporadic tour of some private hospitals confirmed the fact that the professionally trained nurse was being replaced by the cheap to maintain "aides".

It was interesting that even though the practice of lay care taking in the hospitals had come to be regarded as a norm, nursing professional bodies in Kenya vehemently opposed the training of aides. There was need for a way forward on this matter.

Let's face some realities. The mainstream professional nursing in Kenya unlike elsewhere was yet to take up the challenge to fill up this gap even on a side hustle basis. Certainly nurses may not take up (fully or otherwise) the roles that aides take in home care. Currently home care lacked a tailored medical insurance package or reimbursement. The job was fairly tedious with uncertain income such that most nurses would not readily consider it.

There was no denying, home care was an emerging area of unmet need. Could there be by any rate any sanctioned training for them? How then do we regulate it such that aides would do home care giving and not 'nursing' in hospitals? These seemed to be the bone of contention. The Muranga County might be leading the way in this area.

Other resources

Some of the online support groups

Blessed Hands Home Based Care Services. Available: https://www.facebook.com/BlessedHandsHomeBasedcareServices

Care giving is different for everyone http://articles.extension.org/pages/9355/caregiving-is-different-for-everyone

Care giver assessment and planning T-care https://www.dshs.wa.gov/altsa/stakeholders/caregiver-assessment-and-planning-tcare

Caring.com https://www.caring.com/support-groups,

Hope Kenya www.hopewwkenya.org,

Care giving support and help http://www.helpguide.org/articles/caregiving/caregiving-support-and-help.htm,

Helping hands Kenya http://helpinghandskenya.com/

Rafa Home Patient Care Center. On social media@rafahomecare Users

and Survivors of Psychiatry (USP-K) located Kangemi, Nairobi

Nanyuki Cottage hospital: http://nanyukicotthosp.org

Factsheet: Caregiver Screening, Assessment, and Planning Through the Family Caregiver Support Program. Available: https://www.dshs.wa.gov/sites/default/files/ALTSA/stakeholders/documents/TCARE%20Fact%20Sheet.pdf

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CHAPTER 15

'If Money Were Not the Problem', Embracing Technology

Overview

Healthcare costs represent an increasing percentage of gross domestic product for Kenya; this rising trend had created an urgent need to put in place innovative and cost-effective methods for delivering healthcare. It might become increasingly possible that due to the significant cost associated with healthcare, any growth that could be accrued in the future will effectively be "wiped out" by increasing healthcare costs. Much of which will have been brought about by increasing technology.

A colleague who had just returned from an overseas assignment quipped, *'It's adaptation to these new technologies that will keep nurses as a current and vital profession. We need to eat and sleep interactive charting. We need to embrace remote monitoring'*.



Pic: Digital care [courtesy of the clip developer]

As I start from where I stand, (never mind the past) my vision 'if money were not the problem' holds relevance because it is futuristic. The future is in automation, staff and clients of health care should be able to perform and access services in a decentralized manner.

My administration would organize a check-off and time-off arrangement for all staff to become computer literate at a nominal fee. At the same time, implement local area and wide area network (LAN and WAN) and bring them up to speed through reduced buffering and downtime. A reasonable pool of trained technical staff would oversee the undertaking.

The document 'Standards and Guidelines for Electronic Medical Records Systems in Kenya' by the government of Kenya spelled out the vision but the reality on the ground is that in many public hospitals except for billing every other service continues to be done on free-hand, pen, and paper. The clinician writes a set of orders for care, diagnosis, and treatment when a patient is admitted to the hospital. Thereafter, orders are added, stopped or changed one at a time.

Even though some progress had been made in the area of procurement and billing automation of medical records was a long way to go in meeting patient care needs. After the patient had been in the hospital even for a short time, there was no one place where anyone could see all of the active orders for the patient at present. As a result, it was required by policy in most hospitals that all orders be reviewed and re-written as an updated single order in free hand.

But even as we go digital it would be realistic to appreciate that even with the best of effort, the computer entry task would likely take the clinician more time than writing on paper. For the in charges especially, the amount of paper-filling and reporting during month end that they had to do, was variously described as 'overwhelming', 'repetitious', 'confusing' 'tedious' and 'distracting' *'. . .reporting is very important. That will make those supervisors know that you are working because you cannot be seen to be working unless you produce that report'* (Nyikuri *et al*., 2015).

As a starting point from which to develop requirements for new information technology we were still ways away realizing the meaningful use of Electronic Medical Record (EMR), Personal Health Records (PHR), and Computerized Physician/Provider Order Entry (CPOE). It was however important to be aware of teething problems of staff cutting/copy/pasting instead of entering original patient's notes.

It was unfortunate that Cut, Copy and Paste functions had been abused even in the developed countries with working EMRs (Pierre, 2017). Some of these were from multiple sources in an attempt to create what looked like a comprehensive document. It would be interesting if a study say a charts review of copy pasted admission notes, progress notes and treatment. It stifled independent thinking and defeated the purpose of individualized examination, treatment and care.

There was an intergenerational angle to this matter with younger care providers being more than ready to engage in the sloppy practice than the predigital generation. Apart from the fact that it showed lack of concern by the healthcare provider towards ethical standards, there was an ever likely possibility of adverse clinical events. If the client were to find out that this was being done by their care provider he would be very disappointed and possibly sue.

This was a serious problem which was likely to be widespread with no easy solution. It was likely going to be one of the serious teething issue Kenya EMR was going to face. Pierre (2017) suggested that edits in patients notes should be tracked for author ownership as happened in Wikipedia. Some facilities had disabled the Ctrl+C and Ctrl+V functions of the EMR.

While there were great opportunities for all these healthcare systems, *m*Health or mobile healthcare was a reality due to the advent of handheld devices like smart phones which could be made more available to - full adoption. The winners in the coming age will be the organizations that use technology, use larger, faster and more disparate data sets to improve patient care, reduce costs and manage performance.

According to Susan Hassmiller, a Senior Advisor for Nursing at the Robert Wood Johnson Foundation on *Nurses role in healthcare reform*, nurses generally were frequent

technology users; more of them need to be at the table to help make decisions about designing and procuring the equipment that helped patients the most.

Quality of care and medical records

Overall, urgent efforts are needed to improve the quality of care in public facilities. The assessment found that medical history was well documented only in 60 percent of cases in the wards, and 33.5 percent in outpatient services. The table below summarises the findings on quality of care.

Quality of Care and Medical Records, June 2014		
	Outpatient Department	Wards/Inpatient
History well documented	33.5	60
Examination documented	38.7	56.1
Vital signs recorded	32.9	51.0
Appropriate investigations done	32.9	57.4
Clear diagnoses made	52.3	63.9
Records signed, dated and timed by clinicians	30.3	37.4
Treatment sheet clear and signed	43.9	54.2

Source: *Health Sector Intergovernmental Consultative Forum, A Summary of Discussions* held 27-28 October 2014 Panafric Hotel, Nairobi. PDF available:

http://www.healthpolicyproject.com/pubs/782_HealthSectorInterGovernmentalCosultaALNov.pdf

15.1 Envisioning using Human Technology Interface (HIT) tools

The following modified essay was first done as an assignment in this author's coursework in Human Technology Interface:

'To support and augment the role of practicing nurses in our health care facility and given the opportunity to be an executive involved in policy making, this would be my vision for delivering Human Technology Interface for my health care facility as a project. By believing that every struggle that the health sector was going through was an opportunity in waiting to be exploited. If we could turn some of the obsessions we have about quality health care into something that answers some of the questions.

However, HIT was not business as usual in almost any Kenyan health institution. The support of management is as vital as identifying champions who should be respected members of the clinical team, a report by Adler (2009) emphasized unless you, "Identify an EMR champion - or don't implement." Further, as an executive, I would determine the needs of the end user (clinicians and patients) for any of these technologies and then work with IT staff to facilitate a resolution one thing at a time.

A reality check showed that health records in Kenya were paper -based files, primarily to record medical information in a clinical setting. As such, the record was provider-centric, consisting largely of clerking and continuation notes inscribed mainly by a doctor while charts and care progress index notes are usually by the nurses. We had some high-tech

equipment (MRI, CT scans, mechanical ventilators etc.) in major hospitals with some to no HIT except for Scanners and Faxes.

Nursing practice had generally lagged behind the progress made by medicine (therapy), as most had focused on evaluating decisions nurses made, rather than tools to help nurses make decisions. These were observations in Anderson & Willson (2008), Ministry of Medical Services & Ministry of Public Health and Sanitation (2014).

The move towards HIT was the way forward for our health care system, such that an article in Health Data Management (2010) quoted one provider who said that 'a healthcare facility wouldn't dream of not having a telephone system for communication and for upcoming generations, a computer communication system will be just as vital'.

Blumenthol (2010) put forth a case for HIT by saying that widespread use of electronic health records (EHRs) in the United States was inevitable, 'inevitability did not mean easy transition'. Once patients experienced the benefits of this technology, they were likely to demand nothing less from their providers. In any case an integrated electronic medical record is not only a repository for patient information, but also a means of creating and communicating care planning and patient response to treatment.

I envision that health providers will begin to shift from paper-based to electronic health records (EHRs), even if we begin with a digitized version of what we have in paper and later use it to support just about everything we did. Automating routine processes, from documenting in the EHR to the doctor/nurse on call. These would be compiled from: care plans; vital signs statistics; the lab reports; nursing assessments and patient inputs; by use of remote monitors integrated with room light system to prevent falls etc.

Pharmacy programs (CPOE) would manage orders, alerts on errors; do complex calculations for medications and total parenteral nutrition, dosages, and interactions. A dropdown/pop up menu that included capacities to perform drug formulary checks, provide for patient's transitions between care settings or personnel. All these would be integrated and could alert the EHR system with a warning.

We would need to input these and keep it current (Staggers, 2010). It must consider current staffing and workflow. This would follow principles on how Computerized Decision Support System (CDSS) can be built into EHR systems to prevent critical errors and promote safe, effective and efficient use by all end users (doctors, nurses, administrators, patients, and others), following guidelines available at http://www.nist.gov/healthcare/usability/framework.cfm

These tools had something in common, that is once you start using them; you won't go back to your old methods. Once you start using them you go paperless, *you become digital.* Fortunately or unfortunately it usually ended up like someone described as *nurses moving from patient to patient behind rolling black computer pods.*

For staff working in Kenya loss of internet connectivity can become a daily struggle. We needed to push for a national broadband solution that could do the job. The option would then be the smart phone. Mobile phone technology can support clinical decision support (CDSS) system. CDSS was a computer-based health care system which was designed to assist health care providers in decision-making tasks by making inferences (patients' information and the knowledge base/artificial intelligence).

Robert Hayward of the Centre for Health Evidence 'CDSS links health observations with the knowledge to influence health choices by clinicians for improved health care. It uses two or a number of items of the patient data to generate case sensitive advice at the point of care'. Through this interaction, one could figure out the diagnosis, suggest drug interactions, outputs, or make analysis and improve final results etc.



Pic: Transcribing freehand to electronic and vice versa

(Courtesy of the clip developer)

According to HealthIT.gov, the leading US national resource on health information technology (health IT) for both consumers and health care professionals, it had been said that CDSS was the highest level of Electronic Health Records and integration of the two was vital. (HealthIT.gov). Decision support systems and prompts that support practice (such as decision-making algorithms) have a positive effect on aligning practices with the evidence base. The user remains liable to the clinical decision.

This computerized knowledge management had consistently demonstrated significant improvements in provider performance and inpatient management outcomes (Titler, 2007). Marita Titler was the principal author of the Iowa model on evidence-based care (covered in chapter 8).

We would have to invest in infrastructure, provider buy-ins, workflow redesign, adequate technical support, uncertainties on return-on-investment and the chance for low productivity at the piloting/roll out stages. Baicker and Chandra (2011) acknowledge that "In an efficient system, more spending on health care would be a sign of prosperity and a harbinger of improved health and longevity, not a cause for concern."

We would have to contend with the fact that most of the significant savings and productivity gains accrued over a period of months and even years. It was also important to realize that technology was not always adept at solving nontechnical problems - *a better clock does not eliminate chronic lateness and tardiness.*

15.2 Transforming Practice to Promote Consumer Engagement

As concerns consumer engagement, it was true most of our patients did not grow up with technology and many health care providers had no experience in using technology gadgets. However, in Sub-Saharan Africa, millions of people who never used traditional landlines now used mobile phones on a regular basis (Betjeman *et al.,* 2013).

The Kenyan public was becoming more comfortable using the mobile phones hosted internet to access information including bank accounts, although this was the case, the health system needed to reboot sort of to accommodate these.

Functional and structural properties of mobile phones, such as low start-up cost, text messaging, and flexible payment plans, make them attractive to users. A *kaduda* –a popular name for low-cost phones promoted by most networks costs Kshs 999 (approximately $10) it had many features including internet, FM radio and Bluetooth). We need to take advantage of the availability of internet mainly institutional, cyber café, certain central business districts (CBD's), and mobile technologies since few Kenyans had personal computers.

Under the *Vision 2030*, Huduma centres countrywide were installed with the latest ICT technology to enable customers to access some services at the click of a button through the *e-citizen* web portal, Smart-board monitors, as well as TV sets, were installed in every waiting bay and rooms with user-friendly messages so the users could access the information they want in order to become more engaged in the service (see **The annoying sticker** below).

The annoying sticker

One client hailed the *huduma centre* approach. She recalled with nostalgia how things used to be in the previous setup. One department that gave a highly sort after service had over the years prominently displayed certain annoying stickers at the reception like one that read**: 'Poor Planning on Your Part Does Not Constitute an Emergency on My Part'**. She would not easily forget that one because it made her feel intimidated even before stating what brought her.

What would the reader make of this one: in one level six referral hospital had a singular sign post along one of its corridor, with the mortuary taking up a commanding font –

Ward 1, 2, 3, 4, 5 Mortuary

Someone shared that it was unethical in an African context for patients to use the same entrance with those going to pick bodies for burial. It was worse in hospitals which served as the county morgue meaning crime scenes and such like dead before arrivals were using the same mortuary. Now and then as you make your way with a sick person you meet with a police vehicle dropping remains of some decomposed body beyond recognition.

Alongside the Huduma Centre model it was possible to envision that a hospital would create a website to start with and later personalized patient portals, where patients coming in for outpatient procedures/surgeries could access information regarding their specific procedure, before and after-care instructions, access to labs and test results, medications to take or stop. Each webpage would be fitted with a flickering options such as *chat, downloads, add-on apps* etc. During any clinic visit, nurses and other clinicians would then be encouraging and educating patients on the use of the hospital website made available to them.

In future, each nurse would have an iPad tablet or laptop and can input his/her assignment for the shift as will appear with each patient represented. The younger, more computer savvy nurses would have fewer problems adopting; were more daring, they could find shortcuts and links, weren't afraid to click around and see what happens!

If we are truly at the crossroads of transforming health care, nurses must have the knowledge and skills to use disruptive innovations to facilitate and encourage new methods to deliver health care (Skiba, 2010). This would need be implemented in a culturally appropriate manner in order to enjoy significant support. Understanding what works, where, when and how.

Nurses must become more informed and responsible for the care they deliver due to new demands being made by patients and families who were increasingly healthcare savvy due to knowledge gained through the media, technology, and the Internet (Curley, 2004). Luckily some of this was available from Implementation guidelines for the Kenya Quality Model for Health (KQMH, 2011) and *Guidelines for Electronic Medical Records Systems in Kenya*.

Most of our IT hardware and software was imported from other countries, vendors of EHR systems must ensure that they "include providers who serve minority communities in their sales and marketing efforts" Blumenthal (2010) e.g., incorporating language options English, Kiswahili (the national language). There was need to have EHR program representatives on the ground to work on concerns about technical support, security and privacy safeguards.

The need to get patient support for use of the tool would also enhance provider motivation to adopt and implement new systems. “What is needed is technology solutions that put doctors and nurses back at the bedside, optimize their efficiency, improve outcomes and restore the sacred patient-clinician relationship.” Added Bridget Duffy, MD, Chief Medical Officer of Vocera Communications ‘There are many technologies that can improve healthcare; however, some detract from the patient-doctor-nurse relationship," But more importantly for resource-constrained setting, can we really afford the toll that some technologies take on the staff? Especially taking the already insufficient numbers of nurses away from the patient?

15.3 Human-computer interface issues related to Personal Health Records (PHR)

Concerning Personal Health Records, as the Executive, I envision a functional PHR by participant's ability to exchange data with an EMR system. This functionality would allow a provider to download the data that was entered by the patient into the providers' EMR. It would be very necessary to define the user level (experts, intermediates or novices) that the system is designed for, where the human factors must be taken into consideration.

To start with this might have to be a provider-owned and provider-maintained digital summary of clinically relevant health information made available to patients first (later rolled out to other members of public). At this level, the PHR would be read-only for the patient, while the provider supplies, controls and maintains the data, which the patient was permitted to see (Endsley *et al.,* 2006).

For example, permit patients to see a limited set of information, such as lab test results or radiology interpretations, assembled from their electronic data archives, available to the patient from a password-protected Web site. These would be escalated later to enable inter-operability and data exchange through the patient's portal using simple interfaces, that they can log on and know exactly what was going to happen next.

I would advocate for a web-based software first and then roll out the next software that can reside on a patient's computer, analogous to using software such as *Quick files* to manage personal finances (Endsley *et al.,* 2006). In about a year perhaps, with infrastructure in place, we would move to a patient-owned software PHR program that lets individuals enter (read and write), organize and retrieve their own health information. It would capture the patient's concerns, problems, symptoms, emergency contact information, etc.

Interaction with the computer would be made more possible by utilizing add-on hardware technologies (cameras, haptic sensors, olfactory, micro/earphones and other) which give "the promise for effecting a natural and intuitive communication between human and machine" (Corso, 2005 in Fetaji *et al.,* 2007). We would have, to begin with many types of Form-Filling Interfaces because it is the simplest style of interaction that consists of the user being required to answer questions or fill in numbers in a fixed format rather like filling out a form primarily for data entry or data retrieval.

It must be updateable, upgradeable and interphase with many gadgets must meet a 'No advertisements' criteria to avoid distracting the users. This was supported in a policy document by the Ministry of Health, Kenya (2006) 'Taking the Kenya Essential Package for Health to the Community, a strategy for the delivery of level one service'.

I would impress on the need to outsource some of these services from credible firms and ensure that the component of maintenance, as well as training for patients and staff, as part of the contract. It was no longer cost effective for every organization to provide every service. I would need to work on the issues of availability of smartphones, plug and play USB devices, *Micro SD*® cards or media storage devices to more people, as it would be cheaper and easier for people to adopt.

Results of two studies in Kenya suggested that SMS reminders may be an important tool to achieve optimal treatment response in resource-limited settings (Pop-Eleches *et al.,* 2011 & Lester *et al.,* 2010). Patients could ask the provider small questions that had a big impact. Short message services (SMSs) were easy, quick and could reach people whenever/wherever they were.

Patients with chronic illnesses like HIV/AIDS, Tuberculosis (including extremely resistant/multidrug-resistant =XDR/MDR-TB), Diabetes, Hypertension would form the initial clientele of these systems since they were likely to be more regular users of prescription refills, and educational materials and which also allowed appointment scheduling.

This would require working with stakeholders including mobile phone operators, smartphone manufacturers like *Telkom®, Airtel®, Safaricom®* to help offset some of the costs for the patient in terms of e.g. data bundles. To get the youth engaged would involve

utilizing games with health maintenance and preventive components. Create the kind of platform that the youth actually want to do, that they will do with all the passion.

According to Commonwealth Health Fund, the benefits of digital health information exchange were widely hyped but patients worried about the safety of their personal medical data. It will not be unlikely to experience person's data withholding in the age of digital health. Once the patient releases their information: How widely will it be shared?

Can it be hacked? Such concerns could prompt people to withhold data from their electronic records. This could adversely affect the EHR, the health care provider and patient's health. This would be a likely scenario in the Kenyan setting as people were generally fearful of having an 'outsider' knowing about their private matters especially health.

In the end, Blumenthal (2017) said, it was up to the patient to choose. "Patients own and should control their health care data and have no obligation to share information that they prefer to withhold." Blumenthal was the Commonwealth Fund President.

When it came to opportunities for personal health improvement if money was not a problem we could envision a 'personal health ecosystem' like *Philips Health Watch*. This was a piece of upgradable hardware that helped users to better manage their health using data from sensors, smartphone app software and remote location support with other value added services.

15.4 Walk-Around Reality Check

Let us start with the testimony of one nurse whose hospital has adapted to digitalization:

> "I see the advantages of having everything electronically, especially for an institution this size. Multiple people can be looking at the chart at once. If I am getting an ICU transfer or an admit from the Casualty Department, I can look the patient up before I get verbal report from the sending nurse. This helps us save time during report, and it gives me extra time to think about anything that may get missed".

So true but then there was the reality that this was not a widespread thing. If only, so lofty. It would be good to move away from the realm of conjecture to the real world of our low-income settings. Utilizing some aspects of Best Care Anywhere Organizing Framework for Resource-Constrained Health Care Settings in Kenya (BCAOFR-CS) the following is what I see concerning having HIT tools working in Kenya. We need a real tech savvy staff and to have many of our services online e.g. labs results. We need to automate a large percentage of what we do routinely.

Transcribing printouts or freehand results or notes would require a lot of work. Improve on internet speed; extend bandwidth to staff quarters and people's homes. Institutional automation would on the minimum, a bandwidth of 5mbps (megabytes per second) with adequate effective routers. Establish more hot spots for wireless connectivity in public places, institutions, and public transport. Even loading again all the manual stuff that occurs after a downtime of the systems I understand would be tough.



Picture: Keeping medical data electronically is ideal. It saves time and can be used more efficiently. [Photo courtesy of Philip Setel – in *The Conversation*]

We could still utilize the limited resources to fashion the best healthcare system possible but first and foremost we must see a future that could be different and much, much better. But where do we begin? We have not utilized the telecommunications that well either. Many Switch- boards (at the organization level) do not have a way of tracing back the caller. A fax was such a precious component that was underutilized running on a telecommunication platform. Call-ins to a manned bay or live video conferences, webinars, Skype were just beginning to take on some sectors of the upmarket population and the educated.

The portable storage devices like CDs, DVDs, and flash-disks had just began having their impact in the health sector communication (though some were fast getting obsolete), but of course, they had no connectivity or interoperability. They had however made a difference. We needed to step out further. We had not yet exploited to the full devices like LED/LCD projectors for educating our clientele.

It had been postulated that if an organization was still successful in this age and time without a website, 3 years down the line (around the year 2020) it will most likely go out of business if it does not have one.

Our organizations can create websites (most public hospitals had none) to start with (and Later personalized patient portal) where patients coming in for outpatient procedures/surgeries could access information regarding their specific procedure, before and after care instructions, access to labs and test results, medications to take or stop, a flickering chat option. There should be an option for downloads and add-on apps.

Websites that were regularly updated and professionally designed. As of now, some were boring. Even the staff portal itself, many staff would rarely use their organizational email due to reported problems of privacy, speed, and limited features. I want to imagine how the patient would interact with a portal like that.

Some hospitals had websites mainly as a corporate image, and local area network (LAN) mails requirements. Many however did not seem to consider interacting with the patients (I am yet to find out how much has been possible in this aspect). *Contact us* option (especially the info@org) for many organizations in Kenya were left unattended, rarely would one get a response, even a minimum of a personalized acknowledgment.

There was this medical insurance company whose toll-free line was unattended (at least it was not answered all the time this author tried. The rest of the lines were unrecognizable by mobile service provider's networks). These were the contacts indicated in the customers' service charter handbills and brochures.

There was need to design something that could create an alert in the system whenever someone was trying to log in. During any clinic visit, clinicians should be encouraging and educating patients on the use the website available to them. Staffs that had no experience in using these tools to communicate with patients needed to be trained and exposed to them.

Most of the nurses who currently are in management are aging (recently the mandatory retirement age went up from 55 to 60) and their positions are being taken up by the younger generation of tech-oriented nurses. Even though the retirement age for civil service in Kenya had been adjusted upward from 55 to 60 years.

In February 2012 then Chief Nursing Officer, Mr Chris Rakuom hinted that 60 percent of the estimated 22,000 *nurses* in the public sector (that was about 13,000 nurses) were just about to retire *The public sector nursing workforce in Kenya: a county-level analysis (2012)* reported. With all these nurses approaching retirement age and soon exiting service this will create serious transition challenges since the government has not been employing nurses for a long time with an evidently poor succession plan for nursing services.

According to Kreofsky (2013), we must engage staff to engage patients. A large population of our patients that did not grow up with these technologies, we would seize the opportunity of the hospital stay to engage the patient (and family) in their health care. Culturally many Kenyans have someone stay with them (as lay care providers) when they are hospitalized. When a person is sick, the focus is on them. But illness happens to the family.

According to Henderson & Dahnke (2015) 'networking can be a tool to foster professional connections, enrich a nurse's knowledge base, and promote timely communication with peers, patients and family members. Yet, if used inappropriately, it can result in professional misconduct'.

We need to educate staff on netiquettes and patients' privacy matters so that they would have productive time while online (netiquette). Quite a number of staff wasted precious time on social media or such unproductive sites. It was easy to cross professional

boundaries through online social media (Chapter 16 discuss in detail aspects of social media and practice).

Health care providers can boost their professional profile and act as a public voice for science. Although the type of online conversations and shared content can vary widely, medical workers are increasingly using social media as a way to share journal articles, advertise their thoughts and scientific opinions, post updates from conferences and meetings, and circulate information about professional opportunities and upcoming events.

Many parts of Kenya internet is slow, unreliable or non-existent. During such moments accessing what has locally (in the memory hard disk) stored can be invaluable. Installing the offline version of the application on their mobile devices is quite helpful e.g. *Medscape, UpToDate, Wikipedia, STAT Ref, GHDon1ine.org* etc.

This proves particularly on the handheld devices since the Internet is usually slow or not available at all in many resource-limited settings. Stories from Maputo Mozambique and Ecuador attest to this. Denise Basow shared an article 'No Internet? No problem Ensuring access to clinical decision support even when Internet is spotty or non-existent…' (Basow, 2013).

All these are when we assume that we have power and internet connectivity. The *last mile project* by Jubilee government would see every primary school in Kenya connected to the national electricity grid. Primary school pupils would be issued with a laptop. Should the last mile project and ICT integration program survive the time, coupled with free primary and secondary education these mix would likely translate into enhanced development.

The *stima mashinani* paraphrased from Swahili *last mile* electricity connectivity and the laptop project to all public primary schools were flagships of the Jubilee government were adding value in health care endeavours too. Whether the residents could pay for it or not was another story.

The headteacher in one rural public primary school which had since benefited from the *i*pads was having to deal with an electricity bill of above Ksh 6000 per month, which was beyond what they could afford to pay. Kenya was yet to come up with competitive players of electricity suppliers into the market. There was apprehension among consumers as to whether what they were being charged or paying was a reasonable bill.

Assuming that the *last mile* as it were was not going to be the longest mile, the more energy we have, the more we can achieve and the brighter our future. We must do everything we can, with renewed and heightened commitment, provide adequate and predictable funding – to get as far as we can … by a certain date. For health care it was also cost effective to have some off grid solutions like solar energy on standby or to use during the day.

Information communication technology is as much a resource for learning and working, as it is a discipline in its own right. Technology-based resources expand opportunities for life-long learning. For example, e-learning tailored to meet the needs of working and other out-of-school people by providing high quality online short courses, modular diplomas, and degrees to facilitate life-long learning regardless of physical location. It

would be good for nurses with family commitments and those living and working in remote areas among others.

Telemedicine refers to the provision of health care services and sharing of medical knowledge over distance using telecommunications and it includes consultative, diagnostic, and treatment services Telemedicine would be an attractive venture and likely to get usability since we already had a rough road network to rural areas of Kenya and all they would need now was a desktop, video camera, power and internet (usually via modem or router stick).

15.5 'When all was said and (but not) done'

There will need to be a fundamental shift in the way information is accessed and shared across the health system through e-Health. A shift from a reliance on tools such as a pen, paper and human memory to an environment where consumers, care providers, and health care managers can reliably and securely access and share health information in real time across geographic and health sector boundaries.

The health sector in Kenya envisions efficient, accessible, equitable, secure and consumer-friendly healthcare services enabled by ICT. In order to actualize this vision, there will need to promote and deliver efficient healthcare services to Kenyans.

To support informed policy, investment and research decisions through access to timely, accurate and comprehensive reporting on Kenyan health system activities and outcomes; improve the quality, safety and efficiency of clinical practices by giving care providers better access to consumer health information, clinical evidence and clinical decision support tools; enable the Kenyan health sector to more effectively operate as an inter-connected system overcoming the current fragmentation and duplication of service delivery while promoting health research and information technology.

The strategic areas of implementation would include Telemedicine, Health Information Systems, and Information for Citizens, *m*Health, and *e*-Learning. (MOH: Kenya national *e*-health strategy 2011-2017).

Even where as it were money was not a problem, a lot of incentives are needed for adoption into Meaningful Use of EHR, to convince users that they are meant to improve the quality of care and lower costs.

It would be good to tell the users that improvements in quality of care would be piloted with policies that support the EHR integration into the local settings. The process impact would be measured in several ways: general improvements in efficiency; savings in cost and time; increased work capacity, ability to independently meet the clients' health care needs through more timely access to relevant information; social; policy, and technical challenges encountered; adoption of shared technical standards; compliance with the accepted standards of care; potential for successful scale-up; opportunity to participate in design, implementation and evaluation processes; ownership of the process by users; even learning as an outcome.

This remained a challenge even for the US despite the incentives. The bonuses which started in 2011 would give way to penalties beginning in 2015 for those who did not

measure up to the all-or-nothing success approach. Health care providers would suffer a penalty of 1% of their pay (*Medscape*, Dec 17, 2014). As the saying goes, 'It always seem impossible until it is done'

But to the extent that e-health can take place with reasonable cost, it seems morally prudent to do so. Great acts are made up of small deeds. We must be willing to start somewhere. Do whatever we can think of while we wait to catch up with technology from the rest of the world.

Somehow we seem to be running along major economies in areas such as information communication technologies (ICT). This is a fast evolving sector and the health sector in Kenya will be a great beneficially. Alongside these, the following quotes by Florence Nightingale on 13th May 1873 still hold true today,

Point to ponder

Do not let the world move on and leave us in the wrong … Earlier in 1872, this was what she had said 'For us who nurse, our nursing is a thing, which, unless in it we are making progress every year, every month, every week – take my word for it we are going backward…'

(Florence Nightingale)

Imagine this: about a decade ago, scientists spent USD$3 billion (Kshs 279 Trillion) to sequence one (1) human genome. Today, at least 20 people have had their whole genomes sequenced, and anyone with $48,000 (Kshs 144 million) can add their name to the list.

As the cost of sequencing drops and research into possible associations increases, whole genome sequencing will become a routine part of medical treatment. It has been said that in the not so distant future the human being will be able to control devices using a microchip inserted in the brain. In Kenya we can testify to some real benefits brought about by changes in technology for example; Routine Ultrasound scans have become a targeted routine part of pregnancy today in many County and Sub-County Hospitals in Kenya.

According to Kenya Bureau of Statistics released on 30th December 2014 Gross Domestic Product and Balance of Payments for the 3rd quarter 2014, the economy by estimation grew by 5.5 % compared with 6.2% in the same period in 2013. During the period of review, the inflation was at 7.54%, the foreign exchange rate was an average of 1USD to Kshs 93.3.

15.6 The *m*Health

The *m*Health is one major component of *e*Health, which refers to the utilization of information and communication technology for health more broadly, including data transmission and video telecommunication via the Internet. Internet-based healthcare (*e*Health) and *m*Health and interventions as used are the focus of this compilation. Mobile health (*m*Health) is the use of mobile phone technology for health-related purposes; it was considered a low-cost technology.

A meeting entitled TEDGlobal 2017 was held in Arusha, Tanzania in August 2017. A collection of TED 45+ talks, interviews and performances dwelt on *m*Health among

others to a great extent. It looked into the gains made in the field. TED is a non profit organization devoted to *ideas worth spreading*(TED.com).

But *m*Health also includes the development and study of mobile phone applications such as short messaging service (SMS), voice calling, and wireless data transmission to collect or disseminate health-related information or to direct care (Betjeman *et al*., 2013).

It had been used to keep care providers and patients better in touch (e.g. by reminder systems), by keeping local health care centres in better touch with referral hospitals (e.g. sending images for expert analysis, providing better statistics so as to better plan actions etc.), by providing preventive health information so as to decrease the number of people who become patients (e.g. supporting them in leading a more healthy lifestyle).

In a Malawi study by Lemay *et al.*(2012) health care providers used short message service (SMS) to report medical supplies shortages, followed by texts to obtain or communicate general information, and then by texts about patients with emergencies. SMS took an average of nine minutes in areas with limited to poor network, whereas health workers in areas without SMS generally had to report any issues in person it could take on average 24hrs in rural Malawi (Lemay *et al.,* 2012).

SMS based messaging systems for improved disease management in the area of medication adherence among patients being treated for HIV and/or tuberculosis (Tb) had shown promising results. The *WelTel Kenya* study was designed to promote antiretroviral (ARV) medication adherence (Lester *et al.,* 2010). They utilized less resource intensive system of weekly SMS text messages inquiring about patients' general wellbeing.

Patients were expected to respond within 48 hours. If a patient reported symptoms of poor health or does not respond, then healthcare providers followed up by phone. The WelTel Kenya trial did not incorporate specific daily or timed medication reminders and feedback as is common practice for such studies in developed counties. This might suggest that improved communication and linking with healthcare providers alone did encourage patients to stick with therapies.

15.6.1 Show Casing Medic Mobile

Medic Mobile is an open source software, meaning it is free to users. It was sponsored by Open Heart Worldwide. It used a basic mobile phone and could work without the internet (offline). The resource hosted a number of downloadable *Do-it-Yourself* tools that can help you to run your own mobile project, even community health workers with some basic education could use it, while the clients had few difficulties getting the message since it used the short message platform (SMS).

The common platform would have: edit, reply, unverify, delete). What one needs is a user guide (with built in tours once installed), the hardware (cell phone), download and install the software, train and deploy. It can run tools like Disease surveillance; Antenatal clinic; Childhood immunizations; drug stocks'.

It is user-friendly in that it one can choose preferred language including Kiswahili, it can do reminders (including auto-scheduling), no configuration is needed to work with your device (phone or computer), can work offline. Runs locally on your computer, contains

different utility forms, reduces paperwork, can analyze data, create charts and graphs, can generate 100 plus reports, and export data. Good for doing registration, tracking, and follow-ups. Through the website, https://medicmobile.org/diy one joins a community of users and can interact to share experiences.

Here is one example from an analysis based on the Medic Mobile Antenatal clinic (ANC) Tool (see A to B below):

A: 75 Active Pregnancies

37UpcomingAppointments (Name, Weeks Pregnant, CHW, Appointment Date, Number of Visits,)

37 RecentMissedAppointments (Name, Weeks Pregnant, Community Health Worker (CHWAppointment, Date Visits, Option send message/view patient history)

67 WomenwithUpcoming (estimated date of delivery) EDDs (Name, Weeks Pregnant, Last Appointment, Visits EDD,Option send message/view patient history).

1 High-RiskPregnancies (Name, Weeks Pregnant, CHW, Visits Option send message/view patient history)

A graph or chart showing MonthlyPregnanciesRegistered

VisitsCompleted So Far Active pregnancies that have had... (1 visits, 2, 3, 4…)

B: 337 Total Births

150 MissingBirthReports (Name, CHW, EDD, Option send message/view patient history)

A graph or chart showing VisitsCompletedDuringPregnancy (Completed pregnancies that have had... 1 visits, 2, 3, 4…)

A graph or chart showingReportedDeliveryLocations Institutional, Home with skilled birth attendants, Home without skilled birth attendants

A graph or chart showing MonthlyBirths

A similar *m*Health platform initiative rebranded "*Jamii Smart*", Swahili for a smart family brought together partners from the Ministry of Health and civil society, Health market Innovations and corporates like Safaricom®, Aga Khan University® among others with the aim of helping accelerate automating, tracking and collecting data for maternal and child health from conception till the child is 5. Launched in 2011, presently active in Kwale County among others it is expected to be rolled out to a national scale, the *m*Health initiative offers pregnant women more choice, control and medical care for them and their babies during and after pregnancy.

It aimed to tap into the huge success of M-Pesa®, Safaricom's mobile wallet solution, into an effective *m*Health solution that significantly improves MCH by modeling on

existing, sustainable mobile technologies from end users. It uses a combination of web portals and SMS to deliver clinical components for pregnant women and mothers with under five's. Using an USSD or short code e.g. **000*2* the client can book, pay, get updates and other statements, thus somehow getting the services closer at the click of a button. It was possible to work in real time in connected areas and offline in areas with no connectivity, synchronizing when a connection is made to a mobile network.

Through the *Jamii Smart* alerts product, mothers now attend more ante-natal visits and can opt for a skilled birth. Another added benefit is that Jamii Smart allows for *m*Savings and *e*Vouchers for mothers to manage their delivery and healthcare costs. Incorporating "Linda Jamii" a medical micro-insurance product by Safaricom® and partners (Center for Health Market Innovations, 2015).

The *m*Health experience whether from small-scale efforts or pilot projects showed that community health workers, as well as women and children, benefited from the use mobile technology to collect field-based health data, receive alerts and reminders, facilitate health education sessions, and conduct person-to-person communication. It improved the quality of care provided, the efficiency of services, and capacity for program monitoring. *m*Health had also shown initial promise in emergency and disaster response.

According to the Cabinet Secretary for Information Communication Technology Joe Mucheru, 'When you train people on technology and they understand it, then they are going to solve their own problems'. Today is about implementing well conceived initiatives which improve the quality of life for Kenyans. The *m*Health experience was one such an initiative.

Livia dawa app was rolled out in mid-2017 covering major towns in Kenya allowed users to order medicine and drugs online from nearby trusted pharmacies. The app downloaded from Google play store to an Android enabled smartphone.

It lets users upload your prescription, order, make payment via Mpesa and the consignment may be self collected or delivered to the subscriber's home or room. There was an opportunity for consulting before buying. This allowed users to save time and money queuing. Pharmacy owners could also track earnings online http://liviaapp.org.

15.6.2 Data Collection *m*Health: A review

Often mobile phones were used to disseminate information to patients, and health care providers. They could be used in conjunction with related software apps, to provide the real-time feedback needed to monitor treatment compliance or effect as we have already seen, but also serve as data collection tools. This could be data collected for day to day record keeping, quality improvement and research among others.

Interrogating Health Systems



Pic: A model smartphone fitted with geosynchronous features

This section reviews two articles. One from Malawi and another one from Ethiopia. The era of smartphones has opened many possibilities in data collection in health care. As smart phones become cheaper and more widely available, it is a realistic option to use them as field research tools. Potential benefits of smartphones according to Carina King *et al.,* (2013) who did a study in Malawi on *Electronic Data Capture in a Rural African Setting: Evaluating experiences with different systems,* Smart phones were:

-Portable
-Internet access
-Could run third party applications
-Near real-time transfer of data collected using electronic forms from remote areas
-Reduce the costs related to data processing (duplicating paper forms, carrying and storing paper forms, and data entry)

Two to three days training was found to be sufficient for the end-user to competently capture data using smartphones in the field using (Open Data Kit) *ODK Collect* and *CommCare* stand-alone apps. ODK Collect is open source 'free' software using Android platform https://opendatakit.org/about/ while *CommCare* had a nominal user-fee if you had more than 20 users. The apps had the ability to collect, process and analyze data. Data could then be texted (a service with cost and network coverage implications), manually downloaded by USB connection or uploaded wirelessly (*Bluetooth* or Wi-Fi). It is also possible to do virtual and cloud storage off site.

Mobile technology utility had evengained unique value in parts of Kenya's arid and semi-arid regions (ASAL). If we go by the experience of *AgriScout* a mobile app that connects pastrolist communities to tracing areas that had pasture and water, updated every ten days. Saving on time, cost of searching and taking chances. However it faced challenges in terms of poor network coverage and high illiteracy levels among others. A mobile health component could certainly be incorporated as an added benefit once the nomads made it to the earmarked places.

Through the Medchat app available: http://www.androidcreator.wm/app262137 one could learn socialization, make friends with more than 30 options e.g. Facebook, Tweeter, Yahoo, Gmail, Hotmail, Eskimi, LinkedIn etc. Medical related options included - medical online, med-procedures, research among others. News options included – KBC, BBC, K24, Nation, Kameme FM etc. Chat box included - Sharephoto, Enofi etc. Betting options included- Sport Pesa, Tatua 3, Lotto, Betway, Bet Now, Mega Dollar, Bet In, BetPowa etc.

Medhanyie *et al.,* (2015) team in Ethiopia were able to customize smartphones for use with *m*Health data collection application namely Open Data Kit. They developed electronic maternal health care .xls forms (similar to other spread-sheets e.g. MS Excel forms) for Registration; Antenatal care (ANC); Delivery; Postnatal care (PNC).

They trained midwives, nurses and community health workers to use the tools. Data was captured in the smartphones and uploaded to the server whenever there was a network connection. It then became available as scorecards on the mobile phone and on the web. All health workers had never had previous exposure to smartphones and electronic forms. Over 6 months, all health workers completed a total of 952 patient records using the forms on a smartphone.

Qualitative approaches comprising in-depth interviews and field notes were used to document the users' perception and experience in using the application and forms. The results were principally about acceptability, then others. The users:

i)…easily got used to the smartphones and *m*Health application.
ii)…forced the health workers to do a step-by-step assessment and ask all the relevant questions whenever they visited a mother. …
iii)…appreciated the scorecard as a way of giving feedback on their performance and tasks. It motivated them to use the application.

Others were suggestions to expand the implementation …to other health issues and having similar applications for services such as family planning, child immunization, diagnosing and treating common childhood illnesses such as pneumonia, malaria, malnutrition, diarrhoea, and others.

Incidentally, for the six months of study no phone was stolen or lost but they complained about short battery life, carrying two phones - research and a personal phone (eventually they started using the research phone as personal phones). Correct and appropriate utilization of the application seemed dependent on the knowledge, competency, motivation, and commitment of the health worker. It was apparent that mobile health technologies had an intuitive appeal.

Other functionalities ODK could do were utilizing Geographical Information Systems (GIS) to map the site's data was collected from. The maps were also interactive. Other tools apart from ODK include *KoBo Toolbox* www.kobotoolbox.org. Online selection assistant tool was available www.humanitarian.nomad.org/components to help in deciding to choose from the diverse tools available. Which would be the most useful mobile data collection tool to suite your needs, it doesn't have to be that complicated.

Infact a project can focus on deployment of these tools to enhance service delivery rather than scientific interests. It is also likely many *m*Health projects are not reported, the reader may even have come across some of them. Somehow, research and mobile technologies seem to be getting well along together. Some have even argued that mobile technologies have also created new research methodologies, and the debate goes on…Updates can be found http://solutionscenter.nethope.org. Another example is *mydawa* *mPower* your health fitness, health services, pharmacy among other services through their mobile phones https://mydawa.com/#/.

The period also saw the development of Vuka County app www.vukacounty.co.ke that helped health care professionals and others cross transfer/swap from one county to another.

15.7 Even before we get there

Making the most of what we have would go a long way into ensuring quality health care. For instance, outpatient consultation could be done more efficiently. Even in the current paper system, it would be critical that the client knows where their records are and send them well in advance of an appointment (where possible).

The information contained in the records was confidential to others but not to the patient. He has the right to know everything, it's about him anyway so in whose interest is it that we should keep it away from him.

Consider coordinating care in advance, so everything is lined up before the patient comes in. This helps all parties to rank the issues - often, not everything can get solved in one sitting but we can tackle the most pressing ones first. A visit like this could be maximized by having an agenda.

Expecting the health care provider to 'clerk' everything in an instant during an encounter is a tall order and would not be a reality. A larger percentage of the decisions that impact care ought to happen behind the scenes and not during the appointment, it is not human to expect the health care provider to operate like miracle workers.

In addition, require that patient puts all the bottles, paper bags of all the pills they were taking and bring them to the appointment. Not to leave out any information about alternative medications they may be taking or other activities that could impact their health. Show the care provider exactly how many of each they are taking.

Sometimes they might have misunderstood the directions on taking them or it wasn't clear. They might have written down a question or two that to ask given a chance. It's important to share their thoughts. Ask for clarification if where they don't understand.

Carry a notebook to the appointment. Just like everything else, do not figure out everything that was said, refer. Even a sketch on a key point can communicate so much later. Show up on time even if you would have to wait a bit to go in. Checking in helps you to settle down and clear some preliminaries.

15.8 Conclusion

In conclusion, the challenges for EHR implementation in many organizations in Kenya would include operating costs, knowledge, infrastructure, and policy among many others. However, if money were not the problem, being an executive at this future-oriented health care facility would be a dream job.

An executive position would be needed to oversee a coordinated seamless continuity of care in all the four areas (HIT tools, *m*Health, consumer engagement and PHR etc.) and a pleasant work environment for all staff, which would exceed or even amaze the clients' expectations. In other words, best care anywhere!

We should however not be ignorant of the other side of technology. Much of the time technology will increase quality as well as the cost which might be unaffordable for many

Kenyans without (adequate) health insurance. Inefficient use of new innovations, on the other hand, could lead to higher cost with wastage compared with an efficient use of thesame technology. This could become one of the greatest cost elements in resource-constrained settings. This can come about due to poor preparation and follow up on the innovation.

One of the bloggers I consider my mentor Elizabeth Scala MSN/MBA, RN of t*he Art of Nursing* wrote this concerning nurse leaders in the situation like the one above *...to pretend that you had a magic fairy wand. That when you wave this wand a genie emerges and grants you three wishes. Suspend all disbelief. Do not worry about time, money, or resources. And brainstorm…what does the ideal look like, what would the working environment be like if this problem was gone, talk about the ideal and what that looks and feels like so that you can get to the where you want to be"stage...'* Available http:// artofnursing.com/5-great-questions-ask-youre-nurse-leader/

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CHAPTER 16

Online Safety and the Role of Social Media Netiquette for Healthcare Disciplines



(Photo courtesy of Anderson and Soderqvist, 2012)

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Overview

Background: This is a mini review on social media netiquette and online safety, subjects of broad interest but which have serious ramifications on practice issues relevant to university students in healthcare disciplines. It was worth considering social media for what it can and can't and won't do for health care disciplines.

Social media was here already, and it's likely that most health care providers use elements of it in one way or another. It is a convenient and compelling means by which to exchange personal information or as some students preferred to call it, your next "story." The open and democratising nature of social media creates a number of potential risks, both individual and organisational.

Medical educators must better inform students that posting self/patients' information may lead to serious, unintended, and irreversible consequences. Employers, and regulators across need to communicate clearly and effectively to students, nurses, and healthcare consumers about the appropriate use of social media. When optimized, social media can make a real difference in patient care or give them a competitive edge.

The digital revolution has caused a strong drive towards open access of information, with the internet making information sharing fast, easy, powerful and empowering. It should therefore not be surprising that by the time the readers come to this page some of the information would have been outdated. Nevertheless, medical ethics as well as general decorum does withstand the test of time.

The goal of writing this compilation chapter was to give the health care provider in resource constrained settings a jump start in these now – and - futuristic technology trends. However, due to the ever changing social media technology and apparent naivety of the authors, except for the responses by the participants in the study none of the statements here ought to be taken as a statement of fact. This chapter was presented with the caveat that the author has no formal communications qualifications or training. All experience was on the job, and self-taught.

16.1 Introduction

This mini review on social media netiquette and online safety on practice issues relevant to university students in health sciences. This also applied across generations of adopters including authors and participants from diverse generations and disciplines, and the general feeling was the same except that the rate of adoption and utilization was apparently much higher among the younger users but there would be some growing pains even among the tech savvy. We chose these students of heath care disciplines with the assumption that they had already taken advantage of the latest information communication technology. We also assumed that they had more to gain than to loose than others (faculty and qualified staff) from social media technology.

However, despite their greater technological sophistication, younger users possessed a limited understanding of harmful consequences of sharing information, maintaining lax privacy practices and taking their postings for granted.

Though social media is a convenient and compelling means by which to exchange personal information, medical educators need to warn students that posting patient information may lead to serious, unintended, and irreversible consequences. Once you click ENTER that's it, it is no longer in your control. There is need for national/institutional policies on these matters.

16.2 How we set out to do the review

This compilation was an evolving emergent design, more inclined to qualitative research. This choice of study was supported by Polit & Beck (2012 p.487) that an emergent design reflects on what was being learnt and not out of a prior theory. Furthermore, Beck (1997 p.265) herself contends that at the outset for (*some*) research, the state of knowledge that is known at each juncture is impossible to predict in terms of its trajectory.

Search strategy was by using FindIt keywords: Facebook, Twitter, netiquette, online safety, human subjects' privacy, patient's privacy and social media, student behaviour +internet. Combining Boolean operators AND, OR, NOT. In PubMed using Medical subheading (MeSH) acronyms and thesaurus as filters to the text words and search query. In advanced search builder combining the search history. Some truncation* and parenthesis () [] where necessary.

Advanced search journal articles, reviews and abstracts. We created frequent email alerts on the chosen collections in PubMed. We the authors shared references and saved compilations on Mendeley reference manager which is an open source bibliographic software. With Mendeley you can create a private or public group and add publications to it.

The following methods were also applied: slightly adapted coursework materials in *Human Technology Interface*, keeping a tab on three subscription social networking groups' sites and postings on social media. The largest sites with the most traffic and users included: *Twitter, Facebook, Google*$^{+}$*, YouTube broadcast myself, Whatsapp, Instagram, Pinterest, LinkedIn, Bitrix24 and blogging among others.* Facebook was by far the largest of them all with about 1.49 billion active users monthly in 2015.

We searched popular social media engines for terms and conditions for use. We also searched some institutional policies on information technology. Referral was also a mainstay method too, this being an emerging area with a lot of disaggregates information - one person knows this while another one knew something else.

The greatest resources were: high volume platforms with possible youthful users in the health sciences campus and referrals to links and hints as offered by those who got interested in the study. It became apparent that the students had what they referred to as favourite applications (*apps*) on social media, we have tried to explain elsewhere what these are.

The original draft was posted in the library notice-boards in the schools of health sciences in the North and South Rift regions of Kenya for about four months, substantial feedbacks including direct quotes were received from students in the Nursing Sciences, Environmental Health, Dentistry, Pharmacy and Clinical Medicine disciplines. No attempt was made to analyse for content for purposes of writing this chapter, however a more comprehensive report was underway.

16.3 Health sciences students and social media

Web and mobile based social media have become an integral part of modern society. As members of an innovative profession, many medics have embraced social media and were actively utilizing its potential to enhance practice and improve health. Social media will play an increasingly important role for health care providers and researchers alike. One obvious use of social media is for communication between health care providers and the public.

Social media is not just convenient it is compelling to university students, it was easily accessible and just like their peers in other disciplines, health sciences students exchange personal information and also admitted that tonnes of patient information was shared online. Students may not be cautious or have conscience that posting patient's information could lead to serious, unintended, and irreversible consequences (then, now and in the future).

Posting of patient content on social media is a violation of the patient's privacy, period! This is unique to the fields of health care professionals, whose roles and their attendant responsibilities continue beyond the end of a shift or training for that matter. Some gross violations might lead to dismissal from training, while others might even affect your licensure and practice in the country or elsewhere (Gunther, 2008).

You do not want to give anyone a reason to doubt your integrity, ability to do your work etc. and that should stay at the forefront of your mind every time you post. It had become increasingly possible for someone to pull up your online platform instantly. Netiquette audit trail had become a reality among some potential employers.

According to Mitrano (2006) there is a possibility that a human resource person on the hiring committee might decide to look you up on the Internet and find what they might consider inappropriate posting. Tracking behaviours like *talking shop* was real i.e. discussing matters concerning one's work, especially on an inappropriate occasion.

Indeed in the past talking shop used to be regarded as a place or group regarded as a centre for unproductive talk rather than action.

Instances had been reported of screenshots of social media postings becoming subpoenead by a court of law as documentary evidence. You would be surprised at how readily and willing social networks supply such posts.

Whether you're looking for a new job, or are interested in staying at your current position, it's important to take a few steps to ensure that everything out there is in line with the image you wish to project. Take down anything that does not show you in the best possible light. There are algorithms that were capable of detecting patterns of traffic coming from certain social media sites over time.

Once something suspicious comes up the radar, the feeds process was then automated, and content identified. At times there's a anxiety over what some subscribers do while online, more than what they themselves would care to know.

It would be good to familiarize oneself with professional/ethical considerations as well as ethics/privacy/confidentiality laws as applied in Laws of the Kenya or elsewhere. Examples include: National ICT policy 2005, the Kenya Communications Act 1998; the Much as liberalization of social media was allowed to take precedence and it's corresponding regulation had to catch up.

Kenya Communications Regulations 2001, Kenya Communications Amendment Act (KCAA 2009), the US had the HITECH Act 2009, medical ethics etc. Harvard School of Law Library blog gave this warning: Collaboration Tools 'if you hope to use these online tools for work on client matters, please be sure to evaluate whether they provide necessary privacy protections'. Last update July 29, 2016 by Jess Rios http://guides.library.harvard.edu/collaboration.

> Irrespective intent for good cause by the contributor, contents must be in accordance with the Privacy Act of 1974 and the Health Insurance Portability & Accountability Act (HIPAA) of 1996. Further, one would be liable if the material, contents or documents violate the Privacy Act of 1974 and the Health Insurance Portability & Accountability Act (HIPAA) of 1996.

The Kenya Information Communication Act 2012 criminalizes publishing of obscene information about a person. It would be good to know what constitutes sharing information in good faith belief and in which contexts, the rules governing the responsibilities in the functional domains Laws and Guidelines for interoperability, data interchange and security. It is nonetheless, at a minimum, advisable to be cautious and apply the strictest legal precedent to any situation (Murungi, 2013). Some of what has been shared may already be under consideration for legal process under the principle of *subjudice*.

Even if consent was obtained from the patient (such evidence and documentation may still not be legally defensible as acknowledgement or supportive information). In any case this consideration should first and foremost need to be available in the posted profile, which many ignore to include.

Photo editing software had been used to de-identify the patient through face blocking etc., but they still pose some of the most difficult legal and ethical considerations in online portrayals including the possibility of questioning the accuracy of underlying data (Freedman *et al.,* 2009; Alana 2013). Protecting patients through good data security

practice should be as much second nature to the healthcare practice as disinfection. Some guidelines on protecting patients are available at [www.healthit.gov]. Consider the following:

> Appeared in *Nursesarena* by Katty 17th Feb 2018:
> 'A hospital nurse suspected to have circulated a picture of late Zimbabwe's opposition leader and MDC-T leader, M T, on his hospital bed – has come under fire after outraged Zimbabweans wrote to the South African Nursing Council (SANC) demanding action. The picture which was supposedly taken at WDGMC Hospital where …was hospitalized shows the MDC-T leader lying seemingly lifeless as a nurse appears to pose for the camera'.
>
> The complainant was one, S M, a registered nurse added, "I am a fellow registered nurse myself and, sadly, l find the actions of your staff member, a fellow professional colleague to be grossly inappropriate, unprofessional and in breach of the Nursing profession's code of conduct. I would like to assume a breach in the local hospital policies as well." [My take (this author) except for the perception that this was a colleague roasting another, it was also possible someone took the photo and posted it. Nevertheless the mess had been done, investigations were ongoing]

State boards of nursing among others may investigate reports of inappropriate disclosures on Facebook and other social media sites. If the allegations were found to be true, nurses could face reprimands, sanctions, fines, or temporary or permanent loss of their nursing license. The American Nurses Association (ANA, 2011) issued *6 Tips for Nurses Using Social Media*. Some basics first "*would a potential employer find any reason to question my ethics or conduct based on how I present myself online?*"

An extract from ANA is included here:

> 1. Nurses must not transmit or place online individually identifiable patient information.
>
> 2. Nurses must observe ethically prescribed professional patient — nurse boundaries.
>
> 3. Nurses should understand that patients, colleagues, institutions, and employers may view postings.
>
> 4. Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
>
> 5. Nurses should bring content that could harm a patient's privacy, rights, or welfare to the attention of appropriate authorities.
>
> 6. Nurses should participate in developing institutional policies governing online conduct.

Six Tips to Avoid Problems *for Nurses Using Social Media*:

1. Remember that standards of professionalism are the same online as in any other circumstance.

2. Do not share or post information or photos gained through the nurse-patient relationship.

3. Maintain professional boundaries in the use of electronic media. Online contact with patients blurs this boundary.

4. Do not make disparaging remarks about patients, employers or co-workers, even if they are not identified.

5. Do not take photos or videos of patients on personal devices, including cell phones.

6. Promptly report a breach of confidentiality or privacy.

The main rule of thumb should be familiar to you: as a nurse, you have the legal and ethical obligation to maintain patient privacy and confidentiality. Consider information entrusted to you by the patient as "identifiable information" know when and how it can be used. This is what they told us in nursing school 'Never discuss individual patients - or their partners, relatives, and friends of patients - even anonymously, within earshot of the general public'. What has changed?

Such identifiable information could cover the past, present or future health of a patient, or it could be something that would lead someone to believe that it could be used to identify a patient (Logacho, 2014). Identifiable confidential information might include but not limited to any expression of opinion about the individual and any indication of intention(s) e.g. to treat etc., unless this information was not already in public domain.

Though not very practical for social media, as a minimum it was advisable to send personal or confidential data via more secure tools like *Dropbox*, *Teamdrive,* open source collaborative software rather than social media where it is possible to transmit (optionally) encrypted files. You can choose who to share with, who can access, can edit, or delete etc. WPS® Writer an open source word processor had this option to encrypt during saving.

For more reliable open source encryption software for data integrity and messaging other tools exist e.g. GnuPG available www.gnupg.org . *GnuPG* comes with adequate manuals, guides and release notes. Some versions for a*ndroid* were available. Key pairs and passphrases could be added or generated to extract the encrypted information.

16. 4 Understanding some of the concepts used in social media

Health care providers, students in health sciences as well as patients need some understanding of the concepts used in social media:

> Social media is understood as online platforms of user generated content for instant distribution, networking, open access two way dialogue. (Anderson and Soderqvist, Working Paper/Technical Report. 20th August, 2012).

A social networking site is an online location where a user can create a profile and build a personal network that connects him or her to other users. It allows people with similar interests, profiles or other commonalities, to share ideas and get connected. In several cases however, it may be a better idea to work with someone with a weaker fit in terms of similar interests but who has a personality more compatible with yours.

Try to see how you can be useful to your buddies first, before he helps you. It's the ABC of networking and social relations (gleaned from Julio Peironcely PhD blog in -

www.NextScientist.com), do not be the perpetual 'ME'-'MYSELF' & 'I' otherwise referred to as the *meaow* in your group. A popular nurses' social network run a *'Be-the-Nurse you would want as a patient'* campaign(www.allnurses.com).

The website knows the user's friends, likes etc. This definition was given in the Pew Internet American Life Project study on social networking and teens by Lenhart & Madden (2007). Through some algorithms it creates and customizes what it considered priorities the consumer would enjoy in their timelines, newsfeeds, and suggestions as entertaining, valuable and cool.

According to Brittney and Kati (2017), different social media platforms had different experiences: *Twitter you retweet*, *Pinterest you pin*, *Facebook you share*. The objective of all of them being: you want your audience to *like* your post so much that they want to share it with their entire following.

However it is important to appreciate that social media is labour intensive. If one hopes to become more engaging it requires ongoing effort including regular tweets, re-tweets, chats, status updates, and interactions etc. The more emotional and personal your posts the better. Facebook had taken such or more steps to keep its more than 1.71 billion members regularly coming back to its social network.

A lot of reports have shown that social media which include message boards, blogs, micro blogs and social networking sites - breaks down the walls of client-provider communication, improves access to information and provides a new channel for peer-to-peer communication among colleagues, consumers and family members. Some students admitted that they operated multiple social media accounts. There were applications that helped them to easily manage their many accounts (sproutsocial.com).

It also helped if health care providers developed meaningful relationships that provide emotional support for people undergoing difficult situations in life, establish communities with similar interests, and empowers each other to achieve their objectives with online peer support. Including patents support groups like Caring Bridge below. There were reports published by *Fierce Health* (2013) that identified best practices recommendations for implementing wide-spread use of social media within the healthcare industry.

It was trendy that students in health sciences connected with colleagues and got updates about all their class work through a fan page. Many institutions (including most universities, hospitals, pharmacies etc.) and interest groups, social media communities also have social media links.

Many provided a link to a Facebook fan page to get frequently updated polls, photos gallery, links, news, discuss issues, posts and answer questions, writes blogs, feeds and connected with others. The Twitter facility was suited for getting up-to-the-minute information about a fast developing topic of interest.

Netiquette on the other hand is the correct way of using internet (Concise Oxford English Dictionary). It governs what conduct is socially acceptable in an online or digital situation (Wikipedia). Though there might be variation between what is considered acceptable behaviour in various professional environments, this review focused on the generic aspects as well as what concerns the health sciences.

This author's take was that students were learning social etiquette from social internet use and progressively became obsessed with virtual reality. They had to switch their thinking

and behavior as users of the internet to being health professionals when dealing with patients. How could they possibly do that?

It is the responsibility as a health professional to protect patient information by never sharing this information. Netizens refers to social media users, which is an emerging vocabulary just like netiquette. To them, a free and open internet was a world they could never live without.

Facebook described itself as a social utility that connects people with friends and others who work, study and live around them [www.facebook.com/about.php].

Why are you not on Whatsapp?

Peer pressure affects many people in as far as social media is concerned. 'Why are you not on Whatsapp Mwalimu? There were several times colleagues have asked me why I am not on Whatsapp, I give them this answer. It was not uncommon to get explicit graphics of people I happened to know whose source could be traced to the students making rounds among staff only 'closed group' site. A couple of years back someone posted disrobed photos of a member of staff from one of the campuses who had was thought to have had a mental breakdown, since then I stopped using Whatsapp.' Do you think pulling out does make one safe? 'I think no but taking a prolonged break certainly is healthy'

(Shared covertly by a middle aged faculty member in one of the universities)

Do you think pulling out does make one safe? Certainly this would be difficult for the youth. You give and take something in return, young people treat collaboration as something they should do, and it's like a big 'investment'. You do your utmost to maximize 'returns'. The question is how? Reduce the amount of effort, increase the benefit. It must appear second nature, something you do. A few times it swallows your bundles, and sometimes it eats them, but more often there is free Wi-Fi, Mi-Fi in the environment. In April 2016 Savco started free Wi-Fi in some matatus, to give people something to do while in the traffic jam… (Savco was a synonym for Safaricom® mobile phone/data service provider, matatus are public service vehicles commonly vans and minibuses.Traffic jams were a regular scenario in big towns and cities in Kenya).

(Shared covertly by a young avid user of Whatsapp)

A lie can travel half way across the world while the truth is still putting on its shoes - Mark Twain. Truth must stand some tests: coherence in terms of facts adding up and corresponding consistency. So much online information should be consumed with a vigilant eye for 'fake news'.
Whatsapp was notorious for spreading fake news according to Portland a communications consultancy firm. A survey done in July 2017 in the run up to the August 8th 2017 general election. Many people (9 out of 10 Kenyans) admitted that they belonged to more than 3 Whatsapp groups. Users rarely bothered to verify the news with mainstream media. It was usually not possible to trace the source of the fake news, or who got it first. A good number of them shared the news without verifying with little restrain. There was a common culture some even propagated by our education system of not questioning facts, corroborate facts, looking at how probable the event or issue could have happened. The sources of fake news ranked according to the study were 25% Facebook while 46%. A Whatsapp group was not accessible to anyone outside the group thus authorities had a difficult time taming the spread of the fake news. Whatsapp. Misuse of communication gadgets had been declared unconstitutional and there was freedom of speech as a basic right.

False news or 'alternative truth' is generally described as phoney as look alike URL mimicking authentic sources by making small changes to the URL. It would be good to check the Tab 'About' section of the source.

[Portland and Geopoll, 2017).

People used Facebook to keep up with friends, upload an unlimited number of photos, share links and videos, and learn more about the people they meet. This might have led to a common youthful netizen behaviour coined from Swahili dialect *umesikieko, zambazaling* for: have you heard rumour mill? Or else please pass it on.

Unfortunately social media it did not make many students we interviewed study feel they were social in the sense of actually spending time with others. Real social activities really were becoming less and less 'social'. It merely portrayed what they wished others to see.

In Facebook, people can *poke* you, or you can poke someone else. *Poke* is a feature whereby users can try to get others to notice them while the Wall is a forum for your friends to post comments or insights about you. One student said: *I can reinvent myself on social media, I tell my own story in the best way I know how, what I go through, and get feed- back.*

16.6 Peer pressure

Many students were of the opinion that just as their peers social media was compatible with their' values, experiences and needs, it was easy to learn, try out, and use. Its results easily seen. *That's what we want, instant this, instant that, instant results! (See* ***Why are you not on Whatsapp? below*** and also ***Generation gaps*** *in Chapter 5).*

Given the overwhelming popularity of social networking there are several applications such as Twitter, Facebook (FB), Google+ Facebook, YouTube, Instagram, Pinterest, and blogging etc. Some were typically used by professionals and job-seekers included Linkedin.com (for making business contacts) and *Care2.com* (for social activists) etc. There is therefore an urgent and all time need to warn students especially in the health sciences of the danger of inadvertent or intentional information disclosure of patient's/client's information (Gunther, 2008).

Statistics indicated that there were more people in the 25-54 years age bracket on Face book than 13-24 years as seen in the table below. It was not possible to ascertain whether this was the case for Kenya.

Facebook Age Demographics (Pew Research Center, 2014)

Age (yrs)	Demographic Number of Users	Percent of Use
13-17	9.8 million	5.4%
18-24	42 million	23.3%
25-34	44 million	24.4%
35-54	56 million	31.1%

Kenya did not actively filter or block internet content. On the contrary the government continued to encourage unrestricted access to social networking platforms and communication application. Contingent to this was in making the cost of internet connectivity affordable and encouraging mobile phone usage. Optic fibre and 4G networks were already in place.

Many young people often spent *reasonable* amount of their attention and energy keeping their Facebook profile current, constantly updating their status, keeping in touch with friends. With over 35 million internet users, according to Kenya Economic Survey, 2016 the digital space in the country is rife for sharing information among others. 88 % of 16-20 year olds in Kenya accessed the internet via their mobile phones (there are certainly newer trends on these and the reader is advised to check).

By the way Kenya was a one of the leaders in ICT technology innovations especially in mobile banking with adoption and use of mobile banking platforms such as *Mpesa* and *Equitel.* Many start-ups were opening hubs office and online businesses in what had come to be referred to as the *Silicon Savannah*.

Mobile telephony penetration in Kenya stood above 77.3%, in urban, peri-urban and rural settings, while 55% accessed internet via personal computers, 56% of 15-24 year olds visited Facebook daily. 53% were on Twitter daily. 68% of adolescents and youth who had used internet & mobile phones said they would want to access more Sexual Reproductive Health topics. These beyond believe findings were presented by Gitau in November 2013.[63]

Many students admitted that they found more fulfilment in reading and sending hundreds of utterly trivial and utterly dispensable messages-; even from those they see frequently in F2F/f-t-f (face-to-face) situations, even though they often met that *distance still mattered* on social media and there were many reasons for chatting or tweeting back a F2F (face-to-face) or sneak peek a FOAF [friend-of-a-friend] or virtual friends, blind mails, *second life* etc. *Even though we are not a centimetre closer when we connect we are never apart. Some called it working apart together*.



'On social media, people are often looking to connect with someone or waste time doing something mindless. They're less concerned with the problems you can help them solve'. (Brittney & Kati, 2017). The two are the renowned bloggers, top leaders in social media, nurse bloggers *nerdy nurse* and *FreshRN* respectively. Together they authored *Nurse's Guide to Blogging: Building a Brand and a Profitable Business as a Nurse Influencer*.

In social media the personal life of the subscriber was as important (or even more important) as the business life. People want to know what you do and who you are. Moreso the crystallization of who you are and what you're about - your personality with your profession and every aspect of your life. They yearn to see how you balance your life, what inconsistencies they could discern. It's like looking for a brand. This was becoming so even as the distance between peoples' physical and digital lives gets blurred.

[63] Utilizing the digital space to address adolescents SRH/HIV information needs Presented by MaqC Eric Gitau, Youth Programme Coordinator, LVCT. 9th HIV Care and Treatment Forum, 13 November 2013, Ole-Sereni, Nairobi, Kenya

The principle if we could call it one why social networking sites worked was because for young people especially many expect others to be available on the site. *It was important to be visible, and there was considerable social and peer pressure for youth to have a presence and a 'positive' reputation on such sites.* Most participants were more interested in building a positive image online; hear about news and events first hand from their networks. *It was critical for one to make themself discoverable, may be by completing personal profile. It is surprising easy to find people you know then you can add them to your, and they can add you also…* In other words social media had been found to be useful for the emotional management of its users.

Tech generation gaps

There was a lot of accommodation in communication to fit into the social identity (in-group) using sheng, slang and jargon to keep out the out-groups. When your student mumbles "NONYA"= "It's none of your business", in response to your simple question of "where are you going with your friends this weekend?" Who should defer to the other?

He has differentiated himself (a digital *yoyo* for youth) from you (analogue middle aged don). Instead of simply saying "It's none of your business", his use of Twitter slang leaves you wondering what the heck he is talking about, thereby creating a gap between his generation and yours. Even the patients are able to relate with those of their age group and we must recognize this diversity. The patient would like to keep his smartphone, iPad etc. and browse as long as he is conscious, is it healthy? A different study is needed to find out this.

'Sush digital' alias digital granny was the opposite of the above. Mary Namuholi, a 61 year old woman from Matete village in western Kenya was one of the 519 women who had been trained in computer literacy, record keeping, printing etc. through a project supported by World Vision. She in turn trained fellow village women (and some men) for 2 days a week free of charge or for a small fee. She also carried out photocopying, typing and printing services for her village. In her own words she networked with other digital ambassadors via Whatsapp.

[;Sush' case was highlighted in KTN News *Mwanamke ngangari* on 4th June 2017; 18.00Hrs].

Some students shared how they would had "war story" competitions to prove how they were this or that and to exonerate themselves from this and that allegation. One seasoned user was convinced that, *'Battles can be won or lost on social media'*. They would also share hints on how to get away with certain behaviours.

Any serious threat? *One may not see it coming. There is an ever present threat of being confronted for past statements. In other words ghosts are never entirely put to rest.* Long after the post (or presumed conclusion) someone stumbles upon it and gives you the most shocking comment, *some debates get reincarnated, trend again, some with even more vigour…*

How intimate could these forums get? Just to have fun or sheer *uchokozi, mchongoano* stuff paraphrased from Kiswahili for malicious provocation. One youth poked another *'… you got 5000 friends, how many inbox have you ever read from one of them?....is FB just for adding new friends so that you can be a celebrity, is socializing all there is to it?'*

'Growing your presence and authority has little to do with increasing your page likes. The number of likes/followers on your Facebook page has no indication of how well your online content will performs. What you need to do is build enough authority to build an audience that engages more with your content. You can do

this by attracting the right audience to your Facebook page'. Shared Modernmom of MM Media Consultancy in her blog. Her motto: *Use the Media; Don't Let it Use You.*

Young medics regularly used social media to network, share notes and stuff. The word *stuff* was the most mentioned across the board by almost all the respondents.

What about time wasted? *Notification emails from groups can be a bother, you see you have to go check now and then…* A mature entry student shared this revelation when we asked him the same question *East Africa gospel artist mama Rose Muhando got the handle on all this face book song released in 2014 popularly known* ***eti wana-chat*** *https://www.youtube.com/watch?v=p1-iSoJNYdY.* ***Eti wana-chat*** *in the song was the reason/excuse for every omission and commission in the youth.* Compulsive internet use can lead to neglect of family, friends and other interests, sleep deprivation and problems with schoolwork.

Social media and Internet for that matter has made the knowledge of the world available to all. *It was a new way of producing knowledge with different possible scenarios. It provided benefits over current practices*. They felt that *this sort of deprived lecturers competitive advantage over their students, kind of eroding their authority*.

It was possible to learn things on their own through YouTube by bookmarking www.*Youtubebroadcastyourself*.com just by typing the word ***how to*** *e.g. how to intubate* then download the preferred Mp4 or high definition (HD) video through *http://en.savefrom.net/*. This was something that their teachers may not have had a chance to do. The teacher would rather cooperate to learn from their younger learners in this, may be correct misconceptions that could come through the online platform.

The respondents admitted that social media had more than its fair share gross negatives including trending *pretty evident hate speech, maligning each other and character assassination. Conflicts often emerge but became difficult to resolve online, the voice of reason often gets submerged.* An extreme of this ethnic stereotyping, dehumanising descriptions and stoking suspicions between communities was witnessed during post- election violence in 2008 and in the aftermath of Mpeketoni-Lamu attack in Kenya.

Through improper use of social media, some subscribers during fluid political seasons took advantage of the painful memories and ingrained fears of ethnic conflicts that most Kenyans harboured. Fanning through '♯Harsh-tags economic boycott by the opposition on perceived pro-establishment companies and cessation/self-determination by Nyanza and the Coast regions in the immediate post 2017 elections and the situation got murkier.

Kenya had become a '♯Harsh-tag Nation'[64] an observation made on the security situation in the aftermath of the Mandera terrorist attack. Many health workers who were perceived to be not conforming to the religious affiliation of a majority in the area left the area. It will take long to repair the damage to the health system, partly attributed to social media.

Short term measures to flag hate speech installation of an early warning system. Although the law had been criticised as unconstitutional for breaching right to privacy. Under the Constitution of Kenya 2010, Kenyans' consumer rights as well as the right to privacy has been asserted as a fundamental right that should be protected by the full legislative might of the Government.

64 'The Trend' with Larry Madowo, NTV, 20hours, 28th Nov 2014

Kenya had laws e.g. Access to Information Act of September 2016, among other justifications allowed online communication to be surveyed, scrutinised, intercepted and information collected.

Filters could also be used to where possible note: polarizing, offensive, scandalous or just inappropriate content. These included applying tools of trade such as the so-called Blue CoatPacketShaper among others. This is an appliance that could help control undesirable traffic by filtering traffic by content category.

Experts noted that The National Cohesion and Integration Act Sec. 13 hate speech law as it was had several inherent weaknesses such that it could not sustain a case criminalizing hate speech in a court of law against social media users. The NCIC law could not stay ahead of the race in matters hate speech since it largely required a complaint to be launched before they initiated investigations into an incident.

If one was found guilty one could be fined Ksh 1-5 m or 3 years imprisonment or both. In 2012/2013 Umati Project monitored hate speech before, during and after 2013 general election. In this study they found that 5683 logged in posts on social media all contained hate speech. One particular post had had over 3000 likes (Institute for War & Peace Reporting – IWPR; July 2013, Issue 354).

There were many positives though some felt we had become *Kenyans on Twitter [@kot]*. According to a Google report in first quarter of 2017, betting sites were the most visited platforms by Kenyans online. (See **Building mountains out of a molehill** below).

In May 2017, S. A., a 28 year old man who grew up in a Kakamega institution run by Compassion Intl, won Sh221 million in a SportPesa mega jackpot after predicting 17 games correctly but promised himself (and others) to stop betting henceforth, but advised others to bet more. It should not be lost that in the 2017 general election, there was a deliberate social media campaign in a bid to unite Kenyans against tribalism for democracy. Examples of such initiatives included *#MyTribeisKenya*, *#MyTribeNiPeace* in other words 'peace is my tribe'.

For health care workers looking to get a second opinion, social media might do sometimes. One writer shared his experience, 'I occasionally post …at this stage to my Facebook page but Facebook comments are always overly kind and rarely to be trusted as genuine criticism, except by the big-headed' [65](Partington, 2014 May 10).

Students also rated social media utility by exploring serious proposals. They referred to sharing your PubMed results via social media '…found a study you want to share on Twitter, Facebook or Google+?' Another one read 'academic social networks have taken off to a degree that no one expected a few years ago' e.g. 'use PubMed's new social media sharing links! Simply search, find a result worth a share, then look for the sharing links below the abstract'.

Noorden Richard (2004), Deputy News Editor at *Nature* did a survey more than 3,000 researchers on *emerging giant social networking*. The survey reported that a subset of scholars regularly visited social media sites to: discover peers, in case contacted, to post content etc.

[65] Partington Stephen D. (2014, May 10, p20). In their own words, Kenyan authors speak: I stick words together and leave the rest to my readers. Saturday Nation; Weekend.

The most visited was ResearchGate (*n*=1589) followed by LinkedIn (*n*=389), Twitter (*n*=330) etc. Results suggested that Facebook was not widely used professionally. Generally, researchers on Twitter considered themselves very active and social persons. Respondents in the humanities, arts and social sciences were less keen on ResearchGate. *ResearchGate is a LinkedIn for scientists* commented Rao Leena PhD in a Blog.

> **Building mountains out of a molehill**
>
> For some strange reason social media has been known to raise stuff (some considered trivia) to exponential levels. The health sector needs to be aware of the positive and negative effects social media could have. Institutions, individual providers could easily find themselves in the limelight for the wrong reason(s). The following two examples from outside the health sector might help to illustrate part of this point:
>
> A staggering 35.6 million real time Tweets were recorded during the telecast semi-final 2014 FIFA World Cup match between Brazil against Germany- (results Germany 7: Brazil 1) making it the most-talked-about, most-discussed single sport ever on the social network.
>
> (CBSNEWS, 07.00HRS, 9th July, 2014).
>
> *Social media was a court as powerful as any other. In the court of public opinion cases were prosecuted, judged and concluded.* Social media outburst on 22nd July 2016 led to the deportation of Rhumba maestro K. Olomide from Kenya. The artist had assaulted a female colleague of his band in the glare of cameras at Jomo Kenyatta International Airport, Nairobi. The video went viral on social media.
>
> Though there was no formal complaint or charge sheet in Kenya, the concern from gender activists among others were weighty enough. He would have performed in a fully booked concert at Bomas of Kenya that weekend, which was not to be. He was deported back to Kinshasha on the next available flight the following day. He was denied entry to Zambia due to the cascading effect of social media. Four days later, his own country Democratic Republic of Congo (DRC) jailed him for 18 months, with no option of a fine for that crime.
>
> (KTN Weekend 23rd July 2016 21Hrs)

For the entrepreneur minded social media is *for "marketing" themselves* for mounting campaigns: http://campaignforaction.org/sites/default/files/Getting%20Started%20with%20Social%20Media.pdf.

Also see how one can create a productive paying blog in the **Nerdy nurse:** 'Starting a nursing blog has made the single biggest impact on the evolution of my nursing career'. 'I can't pinpoint any other instance in my growth and development as a professional that has done more to increase my salary, propel my career, solidify a professional brand, and ability to make an impact on healthcare professionals and patients. It's why I'm such an advocate of nurse bloggers and frequently say every nurse should blog'. 'Blogging and social media make professional collaboration instant and free'.

The best thing about a blog is that it's yours. You decide the editorial line. You decide the contents and the formats. You decide how people are going to see you, how they are going to read about your stuff (Julio Peironcely, blog). You make people aware of interesting topics, research break throughs and, opinions etc. See **Nerdy nurse** below:

Nerdy nurse

> Once a blog is up and going, it is more than worth it in terms of financial returns. Commercial advertisements are looking for high volume (must read) websites to promote their online shopping products. Blogs are proving to be enterprising. I regularly snoop around one Brittney Wilson, BSN, RN *nerdy nurse* and *Health Media Academy* blog http://thenerdynurse.com. She has won several awards for her work. Her's is a living proof that the *What's on your mind* experiences are worth more than we will ever get to know. She has written a guide to Start a Nursing Blog in 3 Easy Steps . She says, *Social media is not going away and healthcare continues to shy from that amazing power it has available.*
>
> [Brittney together with Kati Kleber (2017) authored a best seller *Nurses'Guide to Blogging: Building a Brand and Profitable Bussiness as a Nurse Influencer*].

It costs about US$100 (Ksh 10,000) to put up one of your own. Though it's preferable, you do not have to start one of your own yet. For example through *Bloglovin'* you can make the blog your own, or just follow the things you want in your feed. By blogging directly clicking 'New Post' on *Bloglovin'.* They promised to promote posts to their 10 million (and counting) users to help you grow your readership. By checking out the tag *more stories by this author…* one can keep abreast.

Alternatively one can be a vlogger. A vlog is a blog that features mostly videos rather than texts or images. Many vloggers were mainly *Youtubers*. *Kenyayote,* one of this author's favourite bloggers indicated that free Wi-Fi and free time on campus was a precious resource to the youth that they could make money out of through blogging among other activities.

By mid 2017 the government reported that 40,000 earned from online jobs. Through the *Ajira digital.com* about 6 centres including Kenyatta University, innovation hubs with free internet and devices were being used to train more than 10,000 youth per month who would be ready to take up the more than 750,000 online jobs (*Jubilee manifesto*, June 2017). Through https://www.coursehero.com one could share notes online and make money.

This education platform allows scholars share education resources to help others learn and study, upload semester notes, study guidelines, advice students and answer questions. By tagging specific categories identifying the contents. Another area one might explore was doing products or services features and functionalities for internet marketing as was spearheaded by such outfits as Leyworld's VDS Africa, OLX, PIGIA ME, CHEKI etc. and globally Amazon among others.

Take for example, 'Earn online by posting, commenting and liking. Joining is absolutely freewww.bubblews.com'. *'Take A Ride To Social Media Profits ... Take a Ride to Daily Profits , Earn USD14,000 Monthly Income with Just 5 Social Friends,' posted to nurses' wall recently.* It was not good to be so curious, desperate and naïve about making money online, scams are common.

There was a thin line between real and scams. It was easy to lose hard earned cash. A particular online *-likes* business became a household name in Kenya in 2017. It used to recruit subscribers using a multilevel marketing strategy.

By paying certain amounts of money to join and more to upgrade to higher levels the subscribers just needed to *click* on advertisements (ads), make *referrals* and *likes*. According to experts, a common sign about credit scammers was the astromonous *likes*

and a corresponding number of complaints, that is if one cared to counter check. However it was also true that online business was not about *clicking* or *viewing ads*, it was about making conversions into sales etc.

As an alumnus of University of Colorado this was what was sent to one of the authors here: *Share your thoughts or pictures in social media using the hashtag #iheartcuanschutz or send comments & including as many graduation pictures as you can at: hsl.socialmedia@ucdenver.edu*.

Yet another one read: Leading brands (health insurance, pharmacies etc.) use Facebook and Twitter to engage with their customers. Some students also expressed concern about what they considered *the unfortunate bit* that anyone could do anything on the social media platform *it was very democratic and unregulated*. One said *it was like a fence had been removed, you can be open to any attack*. Another confessed that *there were reports from undisclosed sites of '...devil uses social media nowadays as a potent means of attack?'* Or an afront on the moral fibre of the society. Anyone remembers the craze *#I FIKIEWAZAZI* of early 2018, sensual graphics posted by youngsters, tagged with an express message teasing parents to check them out. It was pretty sad.

However, Twitter had proved to be a great utility among some rural communities. For example residents of Lanet Umoja, in Nakuru County by following their @chief, @assistant chief and @village elder respectively were able to keep abreast on developing issues including health, crime etc.

As Kenya's face of a 'digital chief', Chief Kariuki had won international around Kenya for his use of Twitter, sending out Tweets feeds to the residents mobile phones day and night that conveyed all the news, good and the not so good. The location had an estimated population of twenty eight thousand residents in 2016.



Pic: From this placard it seems the MinistryofHealth and Council of Governors had communicated decisions on Twitter to the striking nurses on the 136th day of the industrial action

16.7 Privacy issues, likes and dislikes on social media

Respondents shared several hints about the world of social media. For example Facebook (FB) default settings dated November 15th 2013 and available at [https://www.facebook.com/full_data_use_policy] 'thanks to the new "Graphic app", any person in Facebook anywhere in the world could see a profiler's 'photos', "likes" and

"comments". It said in part that, '…will be accessible to anyone who uses our APIs such as our Graph API' [https://developers.facebook.com/docs/graph-api/]. APIs allowed for unrestricted public access. Sources from Google cloud platform indicated that even Cloud Storage could be accessed with a simple API, and by adding advanced features *for some flexibility and power* (https://cloud.google.com/products/cloud-storage/.)

Another student shared concerning an advertisement by [www.proxymonster.us] that run like this; *'You can unblock popular social networking sites such as MySpace, Bebo, Facebook, YouTube, Orkut, Friendster and many other sites. Feel free to browse 24/7 and don't forget to tell your friends!'* The following textbox **visiting online** was what one profiler self-updated sometimes ago.

> **Visiting online**
>
> 'My total profile views today: 132, Male Viewers: 62, Female Viewers: 70'. Apparently amazed, she went on to write, 'I can't believe that you can see who viewed your Profile!' One such possibility could be explained by the following advertisement by [www.makebestout.pw] that runs thus, 'To See Who Visit Your Profile…' 'Use Google Analytics to see what the majority of peopleare doing when they get on your site. Are they poking around or are they looking at something specifically? ...' some advice that was given to bloggers. [www.profileview.com]

Many people will generally not like it when someone intrudes into their personal space. The general rule in social behaviour is 'thou shall not transgress thy neighbour's personal space'. These etiquettes might tend to be trodden upon in the virtual environment but this need not be the case. The same care ought to be taken in either case after all they are both about social behaviour.

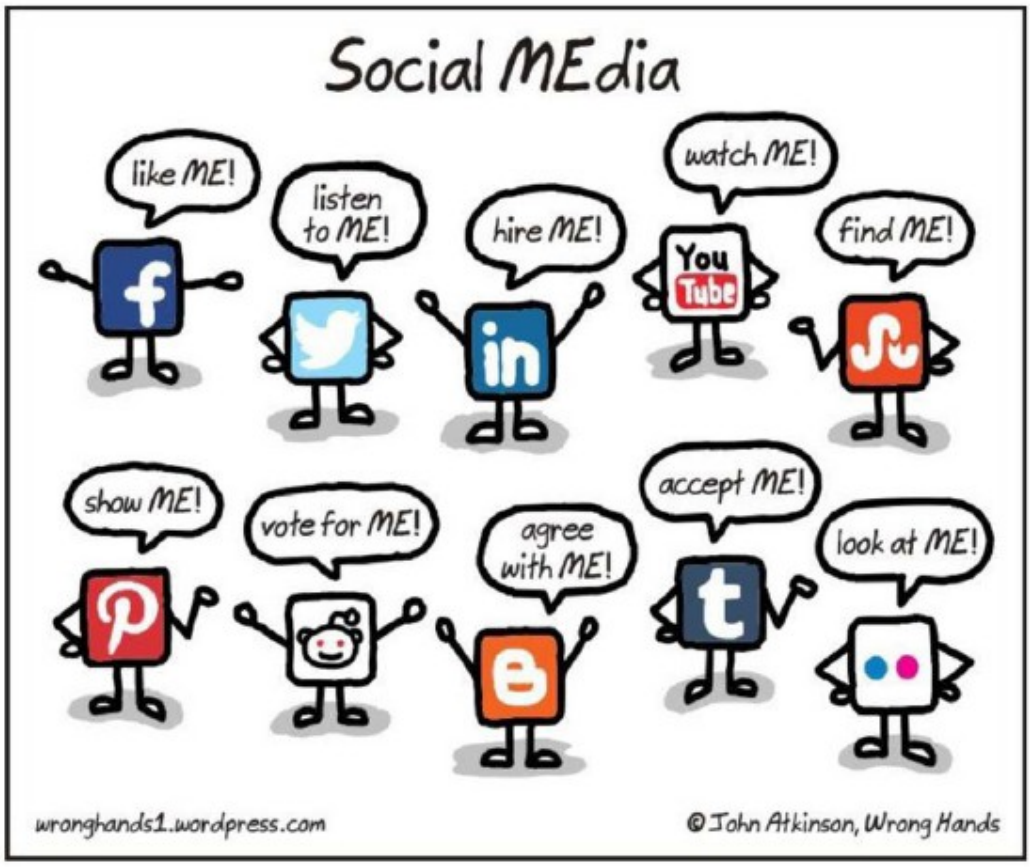
16.7.1 Closed groups

Even though some of the respondents admitted deliberately sharing personal information with the public, the general principle was that in all cases personal data should only be accessible to authorised persons where you can restrict the audience or make it as 'private' as desired. *The social identity in groups was presumed not to rest on the individuals but in a network of social relations.*

They felt *their audience was not public when all parties did all it took to make their group inaccessible to outsiders*. Unfortunately, even in believed *secret but shared* private sites this was not guaranteed. But given the large number of such profiler's friends/users who in-turn have other friends with overwraps becoming inevitable, this notion of privacy too is contextual. Page administrators may have access to insights data.

Once one was in a Group, anyone in that Group can add you to another subgroup (as invitee), as happens in Whatsapp, all they need is your mobile phone number. Unless you exited the group from your end. One student shared with us how it was possible to use tools like *Jing, join.me Google+ hangouts* which were free programs to *record your screen and transmit a 'live' screen to someone waiting for it on the other side*. They can see exactly what their collaborators see on their screen. The effect can be exponential.

But as far as clients whom we serve in the various health disciplines are concerned, their privacy is not contextual; it is concrete, unyielding and unforgiving. If one posted something about their patient (or about anything else) using a social media plugin and did not see a *sharing icon*, it's should be assumed that story has gone public.



Pic: Enticements by the myriad social media apps. Courtesy of J. Atkinson

Mitrano (2006) asserted that as long as goes on social media it was to be assumed therefore that *one* choose to represent themselves publicly and that *one* had absolutely no expectation of privacy. Seemingly, by this virtue one agrees to waive any privacy rights granted by any other law, policy or regulation, for the purpose of making themelves. You sort of agree that your content will be openly available to anyone with internet access, and do not hold them responsible for third party use of the same. With social media unlike email there was no guarantee that one was sending the right people the right content. But still email messages are not as safe as you will want to believe. Tales of leaked embarrassing exchanges are all too common now.

The principles thought to be behind social media simply were: *Liberal, User-Friendly, Shareable, Broadcastable and Searchable* among others. Posted information was not meant to be fitted into a strait jacket but to be understood and interpreted in any number of ways. Scarcely did anyone expect its users to uphold both the letter and the spirit of certain rules and regulations.

Expecting social media to work unadventurously would be tantamount to asking it to do the opposite of its primary purpose. The respondents mentioned that clicking on the *like*

tab to a post might literally mean just anything from then onwards. Generally what kept the algorithm of social media was to become a follower or fan of particular sites, pages or tools, kept *alive when one clicked on these operators: like, follow, comment or share, tag etc. It increased the chance of it posting back (feeds) to you.* These included spam like articles, *click baits* feeds - those that "withhold or distort information."

Google+ offered a privacy tip that read as follows: *Protect your info. Remove your email signature before you reply* to a post on social media. BBC in the episode *World Have Your Say* had been running this agenda 'Should people have the right to delete online material about themselves?' Ongoing from Tue May 13, 2014 17.06 GMT. www.bbc.co.uk/programmes/p01z0wn6

The motivation behind postings on social media remained unknown to immediate consumers' assumptions, whether or not these assumptions were formed within the context that the profiler had intended. Other people, whether we liked it or not, would make judgments about what they saw (Gunther, 2011) based on several factors besides what we had in mind.

Readers may choose to compliment you, may bash you for a typo and they may simply have a smiley face avatar in place of words. It really is up to them. You cannot control them as it were but you can how you respond to their quips, snuffs or instinctive rudeness. Say No to commenting forever to wade off readers' perceptions or misconceptions.

Technology does not absolve us of the responsibility to use it in a legal and appropriate way. Yet several students admitted that, o*ne of the most challenging aspects of instilling a security focus among users of social media was overcoming the perception that "it can't happen to me".*

16.8 Construed meanings on social media

Interestingly, according to Goldman (1999) a patient had the right to control information about self, even after divulging it to others and no one should divulge protected health information. A patient (or a client for that matter) might wrongly believe that a mistake had been made because they themselves misinterpreted their data and were by now (mis)clarifying the meaning and contents.

Think about this: - how can one protect a patient's privacy when they themselves posted or shared their information through social media? There was an ethical requirement to educate patients on the need to protect their own information (Freedman *et al.,* 2009 and Lucila, 2013). This is what some students shared with us:

> **Keeping in touch with patients: how much is too much?**
>
> *'It is hard when families feel attached to you and want to keep you updated (via social media off course) on the patients progress and in turn you are curious as to how they are doing'. 'I worked with cancer patients for a few months and you develop such an attachment to the kids and families that it is hard to not want to stay in touch and updated'. 'Hospitals need to have rules against "friending" patients through social media or posting status updates with any type of identifying factors'. 'I have issues with staff contacting patients in social media. That seems to be breaking aprofessional confidence. Also probably depends on who made the first contact'.*

16.9 Your own privacy as a health care provider matters

On a lighter note, your own privacy as well as that of the patient ought to be more or less your concern too. Be careful what identity you create for yourself online, how you represent others and at the very least, be sure that you take their feelings into account. No one is too small and low profile, to escape the attention of the "bad guys" who run cyber-attacks. They can use your posting to attack say your patient, organization, institution or family. Their unfortunate victims are unaware until it is too late.

Think of the following scenario and figure *what if* two members of the same family got cyber attacked: "*omg* [oh my God] my mom joined Facebook!" one profiler told how she and mother signed up on Facebook. The daughter, needless to say, thought it was "creepy" to have adults, especially her mother, on Facebook (Slatalla, 2007). A paradox on the same, supposedly a parent posted this feed, '*I go to your page because I miss you. Then regret it because of what I see'.*

There can be few things more presumptuous than a self-confessed posting on social media. In this other posting the father apparently was the one who responded, precisely to the point to his son's posting [http://likes.com/tech/]. One way this happens is by creating a tag on you. The lesson here might be: Don't friend your co-workers, don't accept a friend request from your boss (Logacho, 2014), I also add - do not be stingy with *relatives*.

A tag is a special type of link to someone's timeline on social media. *Anyone can add a link to a story and anyone can tag you in anything*. Links are references to something on the Internet; anything- from a website to a page or timeline on social media [https://www.facebook.com/full_data_use_policy].

By the time you manage to block them (some people are unaware or may not bother) they might have siphoned so much. Beware of rogue applications (apps) on Internet. Some sites and apps that use instant personalization (will have partnered with social media sites) and might be able to receive your User ID and friends' list when you visit them. For instance Xperia, Wordpress through Facebook will receive the following information: your public profile, friend list, website, email address, groups and photos once you click Ok. Observing safety thus becomes our individual responsibility.

Options available were few (Gitau, 2013), but of the entire digital platform, Hotline AND NOT social media gave young people the anonymity/ guaranteed confidentiality that most need (even though a referral tracking mechanism exists to follow up those linked to establish service utilization) in order to discuss otherwise embarrassing/difficult topics [Counselling/Info via the 1190 Hotline][66].

Effective management and utilization of digital platforms requires friendly providers trained on a broad range of issues facing young people. This is unlike social media which is mainly a free for all with no one specifically being in control. By and large it encourages subscribers to more than anything else attract fans, followers and friends…

Be conscious of being photographed or recorded. It can take less than five minutes for someone to post (a less than appropriate) photo of you or your patient on the internet or share it with other people. Friends, casual acquaintances and even a 'well meaning' partner could bring you a lifetime of embarrassment from what was

initially meant for their own private perusal, if the photo was abused or redistributed without your permission. After all, what may seem like a cool thing now, it could turn out to be a very much regrettable idea later on.

16.9.1 Security while online

Today basically every other electronic device might be able to store information one way or the other so that our lives have become more and more dependent on them. One might own a smartphone, a tablet, a thumb drive, iPad mini and a laptop, each serves a different purpose. One respondent explained why, ‘

Patient data was sacred

‘In case one device was stolen or lost, I'm losing just the physical hardware. My data is on my office desktop and backed up to a local hard drive and to the cloud, using Carbonite or Degoo. The same way I never should ever loose patient data’.

As seen in the above example, in this digital age it is easy to be in the “constantly accessible state.” Each of your gadgets interphases interoperates the other virtually or otherwise. Meaning that you have turned on notifications of your social media, emails, websites and other applications to your phone, desktop, laptop etc. However this ought to be on your timetable and terms.

The accessibility aspects had made it possible to access and engage with your desktop and library while on web from different geographical locations on the globe. Such that your library is always synced on all computers you choose on web using such software like Colwiz desktop application www.colwiz.com.

This would be useful for consultations, during fieldwork, utilizing redcap or ODK (open data kit) which are useful in community health surveys. Health care workers can learn how to maximize on the social media for the mutual benefit of all. The following courses are open to Kenyan health care providers:

> ICT for health researchers Creative Integration of Informationand Communication Tools and Technologies for Enhancing Research Design, Implementation and Management covers social media as a useful tool. This was among the many online and in-person courses in the ICT into Research Program offered by faculty from the University of Nairobi, Kenyatta National Hospital and University of Washington with funding support from the Fogarty International Center, US National Institutes of Health. Available at: uw_gh_edgh_ictkenya@uw.edu.

Even well-meaning computer users can be their own worst enemies. Why or how? Because they fail to follow basic safety principles like; not using firewall where necessary, not updating antivirus, and not using a strong password/user’s identity or user name. A clear institutional policy might become a safety net e.g. for The University of Colorado, Denver, each student password had to be changed every 90 days.

Logging out makes your computer or mobile device safe from unauthorized physical access. To lock your computer from unauthorized access while connected to a network domain, first and foremost you must associate a password with your user account.

[66] Utilizing the digital space to address adolescents SRH/HIV information needs Presented by MaqC Eric Gitau, Youth Programme Coordinator, LVCT. 9th HIV Care and Treatment Forum, 13 November 2013, Ole-Sereni, Nairobi, Kenya

You can also reinforce by pressing a quick *Windows logo key +L* on the keyboard. Serious things can happen by failing to log out, a determined hacker could access the information on your computer/mobile device if it was left unattended, was negligently sharing files or if it ever got lost. Scammers prowl to get your personal information that you have 'riskily' disclosed. One local blogger shared, *I've personally had a couple of weirdos find my contact information via who is and call me up. It freaked me out and I made sure to put some form of privacy protection after that.*

One Catherine Mbau, a Counselling psychologist with Arise Counselling Services Nairobi was quoted in *EveWoman* Standard on Saturday 15th March, 2014 that the cyber bullies know what to say, how to say it so that it has the right impact.

In the report accompanying this, a number of Kenyan women celebrities had been targeted using the vilest of words. It usually starts with a friend warning you that there is something about you that is trending online, and you go out to check the virtual environment, in the words of one of the women she 'faced a barrage of vitriol online'. Trollers were all over the internet and they wished to make their victims as miserable as they were.

Sometimes social media goes crazy over trivial or sensational gone viral. The term 'go viral' was used for a rapidly spreading Internet message. This multiplies the efforts of the original post and reaches a much larger audience than that subscriber could have done on their own. When a lot of people share your content, it can go viral. Some of these readers repost or follow/connect with the niche of the original author.

More and more students admitted that they went for something trending out of curiosity, some picked it by following popular media personalities, listening in, and calling in shows. NTV hosted a weekend-long show *The Trend* that brought together radio and TV personalities in diverse locations on live teleconference to discuss what had been trending that week. (See **Social media: the new drug of choice** below).

On the other hand potential liability existed for tracking now or in the future with possibilities for: identity theft, co-locate, view "snooping", updating (even distorting) postings, blocking automated annotations or amended feedbacks to the subscriber.

Blackmailers being tech savvy are more than willing to click around to see what happens and place high premium on ready access to information to use, to seek or find mistakes (Gunther, 2011).

Phising is an attack in which one posts into a fake social media site, account that looks exactly like the genuine one. After one enters their password their privacy gets compromised. The rider on this is that the genuine account may become temporarily blocked requiring some several steps in terms of security authentication before unlocking.

This warning message (details disguised for privacy reasons) was sent to a FB subscriber, 'we detected a login into your account from unrecognized device on Tuesday May13 at 9.25pm. Operating system Windows 10. Browser: IE, Location Nairobi, 110, KE (IP *this and that number*). Note: Location is based on internet service provider…If this wasn't you please secure your account as someone may be accessing it. From FB security team'. They further cautioned against responding to requests to provide your login information through email.

Over-trusting technology is another issue. One might feel assured that the correct technical standards were in place to manage message integrity. Would the intent of the message being sent be the same as the message being received and that it cannot give an incorrect interpretation? (Lucila, 2013). Moreover, all digital information was designed to be interpreted by computer programs to make it understandable and is - by nature - software dependent.

Social media: the new drug of choice

'I think social media is the new drug of choice for most people. It is like crack; once you start it is really hard to stop. Even trying not to use your phone to check your social media updates for an hour? It is really tough. There was a time, I would spend between 6 to 7 hours online updating social media sites, playing games and posting on various sites. It was intense. I had to go cold turkey and just stop. I recently went back and I decided to join only "serious" sites and groups on Facebook. They started out well enough but over time, I realised that members started posting personal information and photos. I do not visit these sites and groups too often these days. I joined an online knitting group instead. I also do not like posing for photographs because they end up on Facebook and I do not like that. People just post your photographs without asking for permission. It is really disturbing'.

Another student confessed, 'Its common knowledge that patients' information does rounds on Whatsapp like bushfire, interesting case studies tread in closed group sites but unfortunately they often leak. It's nobody's fault that group norms are not that watertight, it's the nature of social media, and it's the acceptable norm if you ask me'.

On a more serious note

John Horsley, the Director of Digital Doughnut, embarked on a research project. Horsley posted his initial idea and the blueprint of his project on a *LinkedIn* discussion forum and invited the professional community to contribute ideas. Within two weeks, 23 extremely useful comments and innovative ideas had been posted to and shared on the *LinkedIn* page. Moreover, the page was *liked* by over 60 LinkedIn members www.digitaldoughnut.com

The information persists in numerous exchange servers (the sender's, the receiver's and others in-between), almost all handled by third party commercial outfits (not necessarily responsible institutions) located overseas therefore not covered under local laws. There is little possibility of the sender checking for errors or changes that may be caused by the process.

The placeholder for typing on social media is usually small, cluttered and lacks editing tools as would say MSWord with a high possibility of inadvertently posting unattended errors. This possibility increases while using hand held mobile devices, the environment, perceived value of the information shared, competing issues like working under pressure and the emotional state of the subscriber etc.

Even with copy pasted stuff many users agreed for example that highlighting, punctuations, bold text or headers/footers were often lost in most social media platforms. What else could be lost was a major assumption. The terms and conditions for users will Usually issue a caveat that this could happen. Some available at: [https://www.facebook.com/full_data_use_policy]

The Kenya Government on 24th June, 2014 launched a Cyber-Security Coordination Centre to deal with escalating cyber-crime. The *Kenya Cyber Security Report 2014* ranked Kenya among the top countries for most incidents of cybercrime, alongside the United States (US), Brazil, China and South
Korea. The report was compiled by

Telecommunications Service Providers Association of Kenya (TESPOK) and Centre for Informatics Research and Innovation (CIRI). In 2016 the country lost Ksh 17 b due to cybercrime.

For example, *WannaCry ransomware* infections were reported in several countries around the world in May 2017. This was a type of malicious software that infected a computer and restricted users' access to it until a ransom was paid to unlock it. Individuals and organizations were discouraged from paying the ransom, as this did not guarantee access will be restored.

No Post it, Yes don't post it!

I'm thinking and thinking and thinking should I post this? Here goes …. I must confess I didn't Google this person. If she does exist, fine. If she doesn't, whoever wrote these words may have a point. By Aubrey Bailey, Fleets, Hants on September 26, 2014 (Posted in a blog by Dr Rex).

People say things online they would never say in person. Do yourself a favour: don't feed the trolls (Brittney & Kati (2017).

A press statement from the Director General of Communications Authority of Kenya (CAK) cautioned users to protect their information, data, machines and network from the attack. Of particular concern was: do not open unknown emails with attachments with .exe extension. Also, do not run installation of any kind if you are not sure of the source.

In April 2017, a leading national daily[67] run a report – *Hashtag for hire* cited cases involving powerful bloggers who operated with impunity outside of any regulation. They were available for hire to the highest bidder helping to influence, dictate and sway opinions even if it meant 'writing on palmlets' as one legal expert quipped. Sometimes they arm-twisted company CEOs, used fake social media accounts, robots and even dubious blogs.

16.9.3 Simple guide rules

Some simple guide rules applied to social media netiquette: think of physical space both in how you present yourself and how you interpret other people including your patient e.g. what you wouldn't put on a poster on your room door, you might want to think twice or thrice about posting on-line just because someone is not seeing you.

This was summed up by Mitrano (2006) in a Golden Rule, 'don't say anything about someone else that you would not want said about yourself'. Most of all be loyal, to yourself and to your integrity. One student thoughtfully shared these concerning safety while online *if you have a bad or negative experience, warn others without trashing someone else. There are enough words in any language that one may choose to use on social media to convey the strongest sentiments without turning to slight*.

Shea, (1997) added this; when someone makes a mistake, be kind about it. If it's a minor error, you may not need to say anything. Even if you feel strongly about it, think twice before reacting. Moreover, having good manners yourself doesn't give you license to correct everyone else. Further guidelines on internet safety are available at [www.healthit.gov] and [http://csrc.nist.gov/publications/].

[67] The Standard, April 18th, 2016. Special report: *Hashtag for hire*

Ashley Pofit, RN *nurse blog support* gave this advice to budding nurse bloggers, 'share your stories but protect your licence and job… do not write something too whiny… If you are writing about a problem, come with a solution'. *The Conversation* had assorted discourse on social media and health among others it prides itself for academic rigour, journalistic flair. Check link below:

https://theconversation.com/africa/search?adapter=&date=all&language=en&page=3&q=social+media&sort=relevancy

16.9.5 Wait! Hold on - just a minute

This review article is not saying so many things about what cannot be done, on the contrary we say social media and being online is a great thing for students and staff in health disciplines. We simply would like to impress upon them that online social networking sites were, in essence, broad communities with a public audience. *ONE* http://act.one.org actually lobbies *to get internet connectivity to all because it belongs to everyone* and had the power to transform peoples' lives.

Information one may have posted or disclosed on the Internet often was ephemeral, enjoyed only for a short time. The same way certain information communication technology software and hardware have tendency to degrade quickly, unexpectedly and inconsistently in an ongoing - going- gone manner.

However, it would be good to be aware of the fact that the web is invincible, it is impossible to ignore the effects of social media on communication, identity is often permanently archived and might remain accessible long-term to others (Skiba, 2007). 'Once it's online it might as well be written on stone', wrote Brittney & Kati (2017), they are the authors of *Nurses Guide to Blogging*.

Never forget that social media is public, its a public opinion and is often what shapes the agenda of today's world. For instance people will tend to take complaints more seriously than they would in face to face or real life. People will try to follow an evolving debate e.g. your exchanges with say a disgruntled customer, even when they were not commenting you can be certain they note (even archive) how you responded. A good number do follow the reactions and how the matter was concluded. Sorry but, threads have got an indefinite closure period!

Social media portals in particular undergo regular reinvention and transformation, with different apps, blogs, *RSS* feeds, Storify, Tumblr etc., becoming popular for variety of tastes at different times, so there is no end to how much will become available in the virtual space to the patients and also to the health care provider. Some useful information sharing apps in the medical field included: *Medscape, Consult,* and *Figure1* among others.

In conclusion, think in your interests too not only for today, who, what you want to be tomorrow and think of your personal safety. It does not matter why or what it was that was so important and you felt compelled to post that stuff … there has always been the day after.

So, next time, think before you (rip) upload/tag that patient's photo, post on your self-reported FB status. As yet it has been technically impossible to post anonymized on social media. Once you click ENTER that's it, it is no longer in your control. You cannot backtrack or amend later. It most likely has been archived on *as-is* basis as a static record somewhere whether or not that is accessible to you or been cached in formats

irrecoverable by you.

That is, even if you take it down or change it (if at all possible), it was accessible/might remain accessible to the rest of the world on the Internet anyway. One seasoned friend who deals with lots of data said in no uncertain terms *that the most reliable way to dispose of data is by physical destruction*, but how does one do that over the internet?

> Consider examples below: *In the heat of the famous Doctors' strike of 2017, a Dr AK posted in their timeline on Facebook some content blasting the head of state in the meanest of ways. The doctors had been on strike for 3 months demanding higher pay among others.*
>
> *The government declined and ordered them back to work, this irked the subscriber to go bare knuckle in the FB update. '… never set foot in a public hospital… who has never suffered like ordinary Kenyans has no mandate to threaten doctors who are fighting for their rights…' Kenyans came out hard on the posting. It was feared that someone had hacked into that account and posted the stuff. March 8, 2017, www.venasnews.co.ke.*

It seems that an industrial action leads many to throw caution to the wind. Perhaps there was safety in numbers if at all that applied to social media too. This would be an understatement if one cared to analyse one of the popular tweet #ESCALATE related to the doctors' strike. But often with social media things tend to get personal or degenerate from 'social' to personal, and this was what happened most of the time. Let's look at the example below:

> *A group of heath care providers were facing the wrath of Kenyans after making disturbing comments online* originating from a now non-operational Facebook account but archived in www.TUKO.co.ke - *Kenyans castigated them on their disturbing remarks*: '*Kenyans are enraged after a section of care providers came out strongly to defend one of their colleagues by making disturbing comments about patients. Disturbing! Who have Revealed How They Willingly Kill Patients'.* One posting by L K (one of the care providers or a hacker) went like this: "*I feel you guys, huyu inafaa umfanyie … 1000 times, forced to push at …cm before the cervix is fully dilated, insist she's dirty and that she'd shower before you attend to her...*"

It's unfortunate this section needed to be the example we need to use here but then it was in arvived in public domain. It was included here for learning purpose only and no harm was intended.

Rescue Time® records the amount of time one spent on different types of websites. The analytic tools help you monitor the amount of time you spend on "unproductive" websites, as defined by you, so you can make changes in your computer behavior as needed https://www.rescuetime.com/. Rescue Time lite® is an open source app.

There were enough tools to tag and analyse social media in real time e.g. keyhole www.keyhole.co/. Tweeter easily became a battleground in the protracted labour dispute of the Doctors' strike e.g. *#ESCALATE* with militant doctors bonding with adherents and holding ground against opponents. At some point RA a subscriber to this tag on Tweeter had 178,772 Tweets; 642,501 followers; 3,726 following; 1,197 likes and trending.

One distinguished blogger Dr Rex might have thought twice before posting a caption

'clear as mud' which trended for some time Aubrey, 2014). https://hrexach.wordpress.com/2014/09/26/clear-as-mud-by-aubrey-bailey/ comment- page-1/

These are issues for your weighing and considerations. What do you want people to be able to do with the information you have given them, what about future users? What information *about the information* you have shared do you still have?

Degree of openness or encryption - are you the one posting and the user accessing the same information on equal terms? Can you be certain that you have enabled discovery via controlled permission-levels of access to a designated community of users? Can you trust third parties to do so, what happens if they share it out?

It is a NO-NO to debrief about work in the hospital on social media. Sharing patient information on social media is NEVER acceptable. This chapter does not hint or imply that this is *OK*. The author wishes to acknowledge certain delimitation by asking; why a student or healthcare provider would want to put up online, even de-identified patient information. In any case it is yet unknown who, outside of the individual patient e.g. pressure groups could claim a violation when viewing online content some linked to a remotely identifiable situation. This is never OK.

16.9.7 Fast forward

Go forth and venture into the world of social media. Perhaps you might do something very useful or interesting with these social networking tools. Social Media Awards (SOMA) recognized individuals, companies, or institutions that used social media for personal branding, business growth, government concerns, and community development. It is a deliberate choice one has to make; to separate work and leisure and to use social media as a leisure activity, business or charity etc.

This whole debate was somehow summarized in one respondent's statement that, *'we could really benefit from specific guidelines for social media use for the web and other media. Enforcement will be the most difficult thing, I am guessing.*'

Take a break from it now and then. While young people might spend like forever glued on social media, a few good books, on the other hand, that have the power to transform lives and livelihoods – remain on the shelves, unloved and unread.

There might be need for national/university/ institutional policy on these matters. Conduct some trainings, the establish guidelines and best practices. Social media research is a vast field with a lot of emerging issues that constantly point to gaps in current knowledge. A similar review addressing other disciplines and circumstances would be interesting.

These guidelines are for informational purposes only and are not legal advice. They were meant to help one see the opportunities, threats and challenges that one could run into. Give you some sense of how to see them coming, predict them and mitigate the negative consequences if at all possible.

Whereas it was intended that this information would help students and health care providers avoid mistakes on social media, chances are one might use it and make plenty. Anyway, it is this author's presumption that some of the advises in this chapter could be adhered to, but I sincerely urge you to be happy with what you already know in terms of

netiquette, what has kept you going. Feel free to share or send me a review of this chapter, or any other.

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CHAPTER 17

The Future of Nursing In Kenya

Overview

The role of nursing in quality and access to quality health care can never be overstated. During each patient encounter, the nurse is focused on confirming that treatments are successfully delivered, assessments accurately documented, and medications administered correctly. The quality and impact of patient care depend on safe and effective care delivery.

The *Future of Nursing: Leading Change, Advancing Health, the IOM* (2011) identified issues and made recommendations related to the scope of nursing practice; preparing nurses for leadership roles in system transformation; development of nurse residency programs; and ensuring nurses engage in life-long learning. The report identified the close link between the future of nursing and the success of healthcare reform. The report looked at the future of nursing in these respects. Sources from American Association of Colleges of Nursing (AACN) indicated that Registered Nurses comprised one of the largest segments of the U.S. workforce as a whole and were among the highest paying large occupations.

According to the U.S. Bureau of Labour Statistics, Registered Nursing was/is the top occupation in terms of the largest job growth projections from 2008 – 2018. Nearly 58% of RNs worked in general medical and surgical hospitals, where RN salaries averaged $66,700 per year.According to International Council of Nurses, in the *area of policy makers*, nursing's aim should be simple – to be a part of this group, to be able to articulate and demonstrate the value of the contribution nursing can make, and be seen as a credible and integral part of the process.

Many times the phrase "healthcare reform" is mentioned but it is exactly what it is by how it affects your nursing practice. There is no escaping this reality. Nursing education and leadership are critical areas that must be developed and sustained for us to be able to surmount these challenges. Nursing has a long and proud history of influencing the development of new policies in order to enhance the health of the people we serve. Hospitals were going to be paid for the value their services produce, not the volume of services performed. This was already happening elsewhere.

From Florence Nightingale to Lillian Wald, to Loretta C. Ford to Ramey Johnson nurses have been active in directing the policies that shaped their practice and their patients. Nurses today are no exception. That is why it is important for us, as emerging leaders, to understand the importance of policy, advocacy and gain some insight into the strategies that can be used to advance a policy initiative. When she was nearing the end of her life, Florence Nightingale said: “May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done.”[68]

[68] Nightingale F. Sick nursing and health nursing. In: Billings JS, Hurd HM, eds. *Hospitals, Dispensaries, and Nursing: Papers and Discussions in the International Congress of Charities, Correction, and Philanthropy*. SectionIII, Chicago, June 12-17, 1893. Baltimore, MD: The Johns Hopkins Press, 1894.

17.1 Harnessing the Nurses' Voice

In Kenya RNs comprised the largest segment of professionals working in the healthcare industry Nurses make up the largest cadre (over 55%) of the health workforce. They are the initial point of contact for the communities with health care services. Nurses played an important and significant role in promoting positive patient outcomes. Because of this direct effect on patients, nurses must have a constant awareness and a diligent effort to identify and correct problem-prone processes.

But for all the hard work, dedication, and compassion a nurse shows to others, they also need someone looking out for them. In order to help them face the challenges they face, they need representatives in Senate, in parliament, in the counties to help address such challenges from a legislative perspective. The growing focus on ensuring and measuring quality and efficiency of healthcare outcomes necessitates markedly transformed graduate-level nursing education.

According to the Robert Wood Johnson Foundation, nurses are the largest group of healthcare industry workers with the most face-to-face interaction with patients. The Robert Wood Johnson Foundation (RWJF) has made significant and ongoing contributions to ensure that nursing professionals are provided the knowledge and tools needed to deliver high-quality, safe, effective, and patient-centered care. Some of these include Quality and Safety Education in Nursing; knowledge, skills, and attitudes (KSAs) that nurses must possess to deliver safe, effective care; preparing future nurses to continuously improve the quality and safety of the healthcare systems within which they work.

This presents an opportunity for nurses to take a leading role in shaping and improving the patient care experience. One of the challenges the health care system faces in delivering a consistent and positive patient experience is ensuring that employees are on board with established goals and desired performance outcomes. For example, many providers understand the importance of creating emotional connections with patients.

A strong patient-provider connection engages the patient and develops patient relationships that are enduring, promote healing and encourage an optimal patient experience. It has been shown that 84% of healthcare leaders place the patient experience among their top priority. No other health care cadre would deliver on this aspect better than the nurses.

The challenges on the nurse are many and will continue to rise, including emerging technologies and inter-professional rivalries, pressure to give evidence-based care among others. However, other cadres of staff felt the same. Mbindyo *et al.,* (2013) interviewed Clinical Officers (COs) and made the following observation, 'the notion of being 'sandwiched' refers to COs feeling that they were positioned between doctors who had hierarchical authority and nurses who have numerical authority'. Sources indicated that by mid 2017 out of 20,000 registered clinical officers in the country only 5000 worked in the public sector.

Cadres competed against each other, and well they might since not much was being done to address this anomaly. Each new graduate was easily inducted to become part and parcel of the bad game, hence the hegemony each held against the other seemed to get perpetuated somehow. Many a hospital administration usually adopted a laisez` faire` stance on such matters, letting such issues take a natural course. This was a recipe for chaos with each cadre pitting the other, pulling in different directions to the detriment of the entire structure, instead of being driven by a common vision and purpose for the good of all.

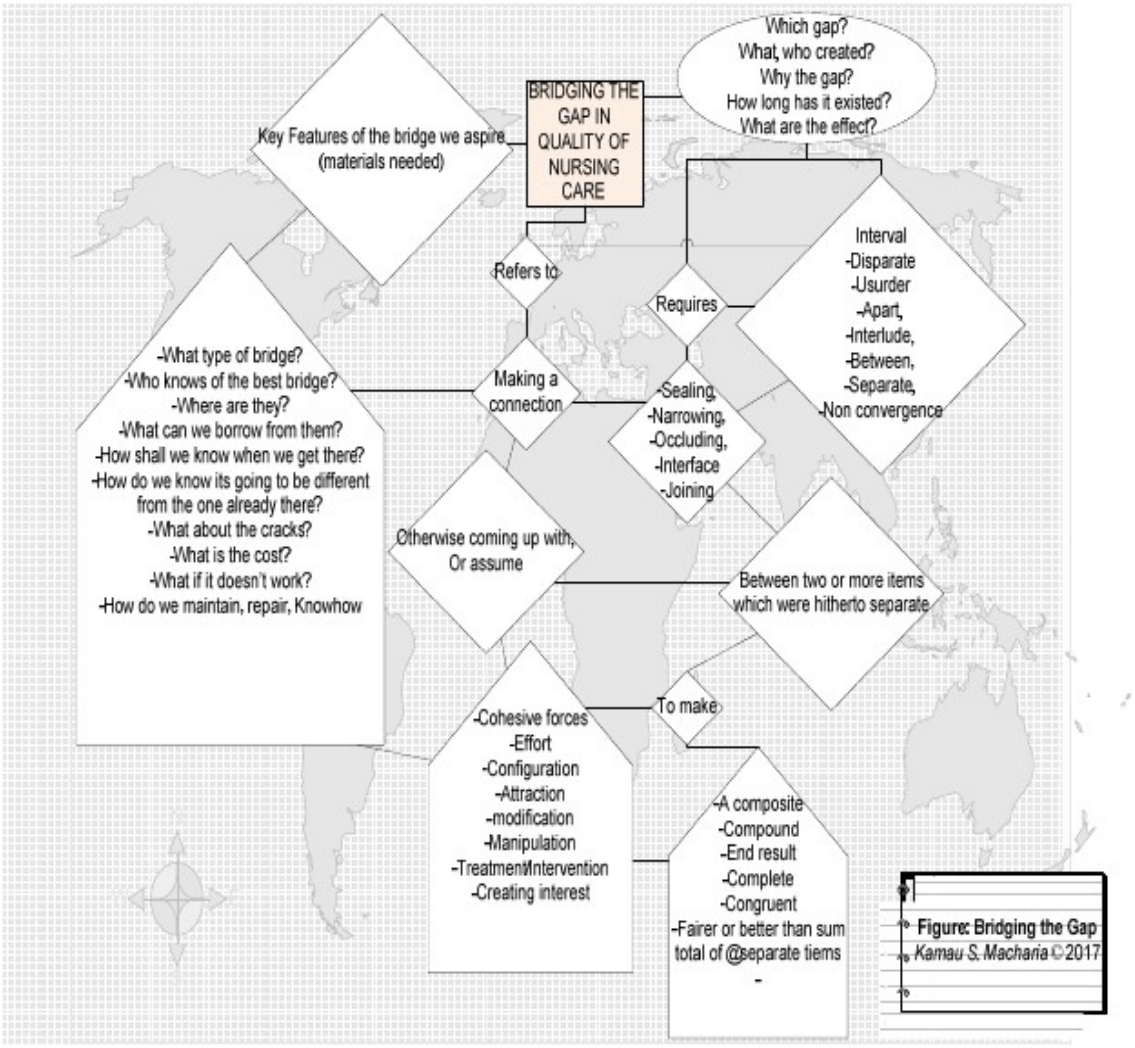


Fig: Bridging the gap in quality nursing care

This author had a discussion with two veterans, a Q officer, and an R officer. They shared some of what they thought were some of the reasons that brought about the differences. There was a lot of unfair competition; the type that some people said *made the sea red*.

Battles of supremacy were gruelling, in one sick bay belonging to a university R was a degree holder actually a job group higher than Q who held a basic diploma. Yet Q was recognized as the section head by virtue of being a Q. In one multi-chain midlevel medical college (s) the glass ceiling was real.

Apparently, there seemed to be an orchestrated effort to ensure that R's did not ascend to level of Principal and that Q's would by default become principals. Despite them commanding a critical mass in terms of faculty and programs, R's usually settled for deputy principals and mark timed there. The trend had been that a paltry number of R's and a few other professionals sometimes would be allowed to become principals whenever new branches were opening but once these centres were up and going they would have to take a backseat or exit. Q's would be the facility heads - period. Their training was usually shorter than R's, it was also common knowledge that Q's were rarely pedagogical scholars or managers by preparation but that did not matter, at least in poorly resouced settings..

A less tedious example but still a source of bitterness was shared one: During their time Q's and R's officers used to do 7 nights duty but while the Q's officers took two weeks off after nights, R's took only one week. Why was this so? The R officer said because *R's liked to oppress each other.* The Q officer, on the other hand, answered *who is this who was going to scrutinize how many offs one got? This arrangement was something that R's were unable to do. Therefore they cannot blame anyone but them.* The Same employer rewards equal work differently, should this be a matter for inter-professional conflict or do we just allow it? In whose interest? Or is it that R's are naïve, fixated in their ways or were plainly a cowardice lot. May be Q's were right and that is how it ought to be for everybody.

During the perennial industrial unrest that faced the health sector in the period between 2013 and 2017, it became difficult to pinpoint exactly where the smoking gun was. What came out as a running theme however were: discrepancies in pay, some called it unjustifiable pay, others discriminatory among different disciplines of staff in the health sector.

An example was cited by one Peterson Wachira, Chair Kenya Clinical Officers Union (KUCO) '… how is it a degree holder (intern) in one cadre could earn 130 per cent over and above a qualified degree holder in another cadre. How?' (6th September 2017 in *The Daily Nation*).

The health disciplines lost a golden chance by failing to iron out once and for all these contentious issues in the passing of The Health Bill Act 2014 which got the president's assent in mid 2017. Much as it was taken back and forth, gaps and even more room for conflicts were created in the bill. May be we need yet another bill?

Infact, the nursing profession has not been able to actualize their collective power. Nursing has not developed into a cohesive, increasingly powerful professional force that could be a partial counterweight to the dominance of medicine in the policy arena, as a formidable power base that is largely untapped in the day-to-day world of the politics and legislation. Nurses sometimes forget that as the largest group of health care providers, they could generate enough power to successfully reform the health care system based on numbers alone.

Abood, (2007) postulated that numbers was one among several bases of power nurses could choose to exercise in advocacy. Powerless behaviors decrease when nurses support other nurses. It would be good to recall that "Coming together is a beginning, staying together is progress, and Working together is success – Henry Ford (1863-1947). http://www.brainyquote.com/quotes/authors/h/henry_ford.html

According to Artz, (2006) involvement of only a fraction of US's 2.9 million registered nurses in even the smallest way could become a force for change for the nursing profession and for the health care system and the patients it serves. Nurses need to be a strong voice actively advocating for positive change.

Nurses cannot afford to remain in the background or added as an after-thought to policy and legislative arenas. Within such a climate the nursing profession must draw on its expert knowledge and experience to improve health care by helping shape effective health policy.

Nurses can strengthen their power base when they network with nursing colleagues and other supporters to build consensus on important issues. Just like one cannot imagine doing research without the internet today so must other matters of professional work life. However, nurses in many parts of sub-Saharan Africa (including Kenya) rarely feel that adequate (International Council of Nurses, 2005).

Nursing can make a major contribution to shaping health policy. Nurses by the nature of their work closely interact with health care consumers in a wide variety of settings. This gives them a broad appreciation of health needs, how factors in the environment affect the health situation for clients and their families, and how people respond to different strategies and services.

Nurses need to occupy front row seats at the point where healthcare policy impacts on patients to protect the health, interest, and safety of the many patients who place their trust in them. Those that are directly affected by a problem should build a capacity to solve the problem.

Not everybody has tested their abilities at advocacy, nor is it everyone who has the facts. We can work together as a unit, where one is certain that what *(not no matter what*) the chairman or secretary general said was an informed collective decision and not their own, that way members can stand their nurse leaders with a conscience.

Advocacy and health policy are a fundamental part of the mission of professional nursing organizations like National Nurses Association of Kenya (NNAK). Kenya Professional Nurses Association (KEPNA), the Kenya Union of Nurses (KNUN) etc. which utilize think-tanks and not the idea of one or two self-styled oligarchs and cartels. Their focus is on the collective interests, values, and status of the profession.

All the more reason why nurses must belong and support these organizations as they facilitate the collective efforts of the individual(s).They require contributive participants (both in substance and ideas) in order to forge ahead, free riding is not an option whereby an individual can benefit from an interest group's efforts without being a member, or at least without being heavily involved. One must make a stand and be ready to support it by any (*not all*) means possible, at least with some decorum and moderation. Remember it's a matter of timing; no force can stop an idea whose time has come.

According to Allen Hays *(n.d)* in an abstract *Democracy papers: The role of special interest groups*, the reasons for effectiveness lie in how a group employs its chief political resources: membership (and more so significant critical mass of actual/potential supporters

and key persons towards a cause), cohesion/intensity, money, and information at its disposal.

Information is the most powerful resource an interest group can have (Hays, *n.d*). They need contacts, insiders; they need to know who the actors are and what the best timing is. For example only a handful of Kenyans are aware or even contribute during public submissions before a crucial bill/budget is tabled to parliament, so even a hundred letters, a flood of phone calls all with the same message can seem like a lot of input (albeit from members of an interest group or from the public orchestrated by it).

If these can have as much genuine grass-root support so much the better. Armed with information it is possible to dramatize a problem. (Hays, *nd*) the link is available in the references.

Carrying everyone along takes time. One has to play by the rules or change the way they play. In the case of nursing issues many stake holders must be accommodated from time to time. These might include market players, investors in health care, insurance companies, professional bodies, unions, training institutions, the central government and the council of governors etc. Advocacy cannot be one directional. You need to ask - who do you need to talk to on this and that issue? Their goodwill in the outset was as good as the outcome.

How you pick up in case of failure of uptake? How do you determine the vibrancy of the uptake? How to disquiet the conflicting voices? Breaking down the complexities become easier since you already have more people who understood the concept. The value of outcome was a derivative of the value in terms of effort.

It was rare that an idea became a hit when very little ground work went into it. It was a process - weaving, soft launching, rolling out and finally controlling the case. Unfortunately, it was often a matter of wanting to jump the gun for many a well-intentioned activists or advocacy groups. They want the results instantly!

A very useful online resource is Community Tool Box had lots of stuff on 'Conducting a Direct Action Campaign' available: http://ctb.ku.edu. Here we are some excerpts from the resource. An interest group needs to learn: that being as organized as possible is key to legislative advocacy, being proactive with reliable ways of deciding on an action, communicating on the action to all those who need to know, being able to mobilize when it needs to be done, carrying out the action in a systematic and effective way.

It is not about a group agreeing on some large issue and then trying to react to (any and all) threats to what they believe in, this would be like harnessing the nurses' voice (knowingly or unknowingly) for the wrong purpose. Hassmiller (2010) a Senior Advisor for Nursing at the Robert Wood Johnson Foundation (USA) asks nurses to:

'Always say "yes" when asked to be at the table. If you believe you're ready but haven't been asked, then ask to be involved in a board or committee of interest'. I have not heard anyone talk about 'Be at the Table". A nurse getting a "seat at the table" has been a long-standing issue for the profession. It became necessary sometimes to fight for space, elbow others in the process. Know how to leverage positions and platforms to demand for their rights. That was why in 2010, a nursing professional practice model (PPM) by American Nurse Association was designed to provide a united voice and a framework for how nursing practices, communicates, and collaborates to provide the highest quality of care.

Serving on boards was a key component for any nurse trying to elevate their career and the profession as a whole, enabling them to make decisions and have a lasting and profound impact on issues affecting nurse safety, patient care and outcomes, and the culture of nursing as a whole

(A Statement by American Nurses Association - ANA Leadership on 13th April, 2017).

Rhonda Anderson, RN, DNSc, CEO of Cardon Children's Medical Center in Mesa, Arizona, "When you are participating as a trustee on a board, wear your RN credential with pride. Your knowledge about patients, your ability to translate patient care systems into financial language, and your ability to focus on how to design future patient-centered systems of care will be [a] significant contribution to that board! Stand up and be proud that you represent the most trusted profession in the country".

A few colleagues shared the following assorted sentiments:

> When I began my career as a nurse (it had been over 30 years down the line), nurses were never asked nor expected to be involved in policy-making. I have been around to see many changes, albeit –I innately think I did not deserve some things to be handed to me rather to actually work to be part of decision/policy making but that did not happen). I can tell you the most successful areas I worked were when nurses stepped up to the table.

People are not going to come to us and ask us information and insight and professional advice and to be involved. *Yes, we can*, *we have to sit at the table!* Nurses need to seek opportunities to serve on a Committee or Board or project of some sort.

Nurses should insist on better stakeholder representation early on though, I do believe we have to eliminate some of the rolls out surprises that we had to wait for fixes on. We can't sit back and be a supporter; we should sit at the table with all the other higher ups or whoever and converse.

"Nursing is a business and it is in the profession's best interest to craft our arguments in a business-like manner" (John Welton Ph.D., RN) as he proposed on *Paying for Nursing Care in Hospitals.* He has done a lot of work nursing care costs, nursing billing, and reimbursement. In his argument, prospective payment system must more accurately represent nursing care. One way was by utilizing nursing intensity billing (Welton, 2006).

When the engineers did the cardiac unit but no patients' toilets, no showers, no changing room. The engineers reasoned, "Because patients don't get out of bed" In one such scenario the cardiac did not have a sluice room, when they were confronted they wished it away they could not find the space. At last, space was found, an odd one though since it was next to the sterilization room, we had to make do with that.

The units were supposed to be opened without air conditioners, the nurses stayed put, they were not moving in without air-cons, period! There had been state-of-art operating theatres that didn't have changing rooms. These are very noticeable errors to someone who works in the area every day (like a bedside nurse). Not any nurse - and especially not the nurse decision makers are very far removed from current unit workflows and practices.

If nurses are not willing to step up and decide what needs to be done, others will. Currently, there are multiple examples of other professionals making rules or passing resolutions to control practice nursing. Moving forward in health care, nurses must be sure they have a seat at the important decision-making tables at all levels to shape policy in national, county government, as well as the workplace and the community (Leavitt, 2009). The policy is a slow process and change doesn't happen that often, so you have to be dedicated to stick with an issue.

At times the most tormenting so-called hospital policies are not even policies at all. Just for instance relooking at **Turbulence** in Chapter 1, was it a written down policy that nurses be surcharged when a patient absconds, again why only nurses?

What of the requirement to record a statement with the police no matter what time day or night it was? What of nurses being deployed to working in the procurement department? Whose interest would they be serving or rather whose interests do they defend and represent? Whose role were they usurping? How would that ensure that the procurement process would be above board?

The public procurement and disposal Act required for public participation, fairness, competitiveness and cost effectiveness among others. It ought also to be clear on who the supplies staff were. Would this not likely lead to the nurse being used to cover up scandals and laxity in the stores? What image were nurses portraying when they did that? How far can they go into other peoples' business, spans of control? Or maybe it is well intentioned as Khoury *et al.,* (2011) Gallup study observed that to improve process efficiencies (some departments; *emphasis mine*) require nurses to provide direction and leadership (see **junks and jewels** below).

Junks or jewels

In one hospital a nurse supervisor admitted that they lacked so many supplies yet the store was full of things! It even had some 3 large containers of goods *which nobody knows what they are;* some have been there for years. Expiry date notwithstanding, in business, you could call them dead stock. Oftentimes their inventory was non-existent. These had come either as donations or perhaps someone ordered them without consulting the users, others the bureaucracy involved in getting them to the user was prohibitive, might have been a syndicate of *white elephant* etc. Whatever it was that caused the phenomena, the fact remains they cost money. One needed to be creative for example - the other day she unearthed model female pelvis, an invaluable teaching aid but only after manually digging through stuff. Some items were good, some just needed batteries others needed repair then they could be issued out.

Apart from the above, there was need for the nursing fraternity especially in Africa to be in a position to make intellectual contribution as leaders. Idea catalysts, thinkers and doers, change-makers, problem- solvers already hard at work. People who can create an atmosphere for curiosity creativity and discovery.

Those unique perspectives by those who can chart Africa's own path to modernity. 'Ideas emerging from Africa have the potential to create a transformative impact not just here on the continent, but worldwide' (TEDGlobal, Arusha August 2017 TED.com). This statement is not a moment too soon. Africa had lately been listed as an exponentially dynamically developing continent, and all eyes were focussed on it

An advert seeking nurses' agenda towards e.g. Sustainable Development Goals should be in a position to receive adequate responses in terms of quality as well as content. Something much simpler - what would they say in an opinion poll that sought their input about future aspirations of nursing?

What of those unbelievable opportunities for nurses that one says - if money was not a problem? Those six million dollar jackpot questions? What of the revered phrase paradigm shift that nurses are fond of alluding to, ever paused to ask what they mean? What has shifted, where is the evidence, what will do so next, can we create that future and how?

These would require transformative leaders in the profession as well as their followers who were nolonger reluctant to invest in personal and professional development. Several investors would be interested to confirm that we have a critical mass (sometimes referred to as think tank) of forward looking resourceful, informed nurses who will make the much needed intellectual contribution. Nurses require an understanding of political context and process to effectively influence policy because content knowledge is not enough.

Back home as long as request for memorandum by legislature continue to receive abysmal

response from the nursing fraternity we cannot make or sustain positive momentum that will take the profession to new heights. How do we keep something ready just in case there was a constitutional moment, a crisis, a disaster, a vacuum somewhere, a breakthrough moment, anything including life in another planet etc. Should we stagger the exceptional potentials we have or explode them?

The reality was that nurses spent an excessive amount of time fixing problems caused by broken and inefficient processes and systems. This was accentuated by the need to interact with so many different departments and services.

While this essentially should allow nurses to spend more time on providing more direction and knowledge while performing leadership functions, this multiple role was unappreciated or did not always pay off as we shall see below. But what with hospitals keeping the nurses' wages low? As one nurse confessed confesed concerning her family domestic budget, '…there were times when I wasn't sure how we would keep the lights on'.

One TV show (date withheld) discussed the crisis at Pumwani Maternity, the Chief Officer Health, Nairobi County and a Member of the County Assembly (MCA)/representative from The County Committee on Health, Nairobi County assumed to know so much about nursing issues that the one member (a nurse) of the panel appeared cornered: while the news anchor/interviewer was after the sensational part, the other two panellists went for a 'blame the victim' onslaught. With all due respect, this nurse panellist tried, and that was commendable. Apparently, there seemed to be much coming his way that he was not expecting or was least prepared.

We should be seeing less of this kind of representation with time as we grow to become more focused and strategic. It is either that nursing gets proper and adequate representation or we reschedule such interviews until an appropriate time.

Of late impromptu press conferences and crisis interviews (some called by 'fire spitting', 'life-threatening', "Bully Pulpit", "flapping in the air" officials) could have derided the image of the profession more than enhance it. This could result in a low trust ranking of information coming from the unions and associations concerning health policies issues.

> I believe there was less one could achieve as a leader by 'cutting off the ears' of those representing the employer, statutory bodies or institutions set by the constitution. Even to those who do not believe in your way, there was need to find a way of passing the same message with less aggression and in a less condescending manner. Be ready and selective as you respond to an opposing argument or controversy in gracious manner was key, do some mental screening process.
>
> Arguments may not always be won on the basis of what was said, but people watch the how, the manner one responds to those who they disagree with including those who are rude to them without going overboard. They will respect or thank you for expressing yourself in a thoughtful manner. As a result they too were likely to support your effort and increase your reach anyhow without questioning your ability to lead.

There was need for deliberate efforts to uplift the nursing profession rather than add to the hordes of negative stereotypes. Help to deconstruct some of the social order that held nurses down especially in resource limited settings.

There had been concerns regarding the availability of effective leaders physically, symbolically and functionally at the operational, clinical, organizational and national levels that could effectively influence health policy. Moreso union leaders who were willing to listen to and accommodate dissenting views.

The revolutionaries needed to transform their ideas into programs offering solutions after making objective assessments on issues. As one KNUN member posted 'a union is not a cult as to be followed and believed unquestioningly'.

Nursing leadership must be seen to lead the way, must be the indefatigable, hardworking team, an enviable team which is ever energized. Why because they have a lot of nurses looking up to them, some facing very basic challenges in order to deliver care. Some of that care could be injurious to them as well to their patients. Leaders need to keep their part of their bargain.

A professional association or a trade union would likely go down if/when its leaders engage in propaganda, positioning and jostling for positions, horse-trading and politics at the expense of the main focus. It was alleged that some professional bodies were known to be misuse students' leaders by co-opting them into their forums, paying them a 'handsome' stipend, never bothering to know when or if ever they go to class or not. This was not good for the nursing fraternity either. It was unimaginable the kind of feuds and cliques that sometimes run these bodies some in the recent past.

Court injunctions after another almost denied the fraternity of leadership at the nursing council and directorate of nursing levels. Regular services like indexing of nursing students at times took more than a year. It was thought delaying of The Nurses Amendment Bill 2017 was due to prolonged wrangles and vested interests within the NCK.

The nursing council seemingly was not soliciting the views of members before implementing several far reaching decisions. For example on 29th August 2017, NCK issued a circular concerning its online services that would require nurses to pay Ksh 2000 annual licensure fee. Previously it used to be Ksh 2000 renewable every 3 years. Verification fee went up from Ksh 5000 to Ksh 12,000. Such drastic changes needed lots of sensitivity and soul searching as opposed to imposing them on members. How could this happen?

The Registrar NCK sits at the governing council of the nurses association (NNAK) and the chair of the nurses' association sits in the board of NCK. R.D. K on nurses' social media platform *Hiyo sioni nikirenew, wacha niendage Kirinyaga Road*, from Swahili-English I am nolonger going to require renew my license if at all, If need be I can get a counterfeit one it from downtown Kirinyaga Road.

> It was unfortunate that many Kenyans (nurses included) hardly appreciated that the key mandate of boards or council was to protect the consumers and in this case it should be assumed that NCK's function first is to protect the Kenyan public not he nurse, and that is the bitter truth. This was unlike the professional association or union. Nurses should not be offended to see that the three do not always agree to agree, though they all are stakeholders in the interest of self-regulation of the profession. As they say in business the customer is always right, so if forced to choose between the nurse and the patient's safety, the results become obvious. However in poorly resourced settings the consumer was not that empowered, but this was likely to be a thing of the past.

By July 2017, it was alleged that nurses in public service were yet to undergo the SRC-initiated job evaluation. Among the reasons being a court case *Petition No. 51 of 2015* KNUN versus Chair SRC and others (2016) *eKLR*. The ruling was that job evaluation was not to be tied to the conclusion of the CBA. During the over 100 days' nurses' strike of 2017, the open disagreement between the secretary general and the chair of KNUN almost robbed the nurses of proper placement in the job evaluation by SRC.

It was alleged that as a result SRC had deprofessionalized nursing to become graded as semiskilled discretionary nonprofessional's Band 'B' who neither made neither decisions nor contributed much towards decision making. Nothing could be worse than relegating nurses in

Kenya to the margin in terms of recognition and remuneration. However there was a state of contradictory positions concerning the issue. This was not until there was a renewed effort to get a job re-evaluation in September 2017. Hopeful this would elevate them to skilled professional specialist 'B' and 'C' or so.

SRC denied it was not the source of the document in SG's possession. The KNUN chair disowned the document too insisting that a re-evaluation was concluded on 8th September 2017. This coincided with the ongoing industrial action day 98th. While one faction insisted the industrial action was premature and ill-advised since there was no negotiated CBA, the other insisted NO calling off the strike until the concluded CBA was signed, registered in court and implemented as a return to work formula (RTWF). The media had a field day seeking counter sentiments from each faction. As usual they disagreed on virtually everything. On 27th July 2017 in a meeting with the CoG, the factions were requested to leave the venue and agree between themselves first.

About a decade ago the *Kenya Nursing Journal*, probably the only one then in Kenya went out of circulation for a couple of editions. When that was not the case this it was alleged that the journal became the preserve of some of the said leaders 'insatiable appetite to publish on every other page.

One way around this used to be to co-opt one or more of them as 'co-authors'. Side-lining others' contributions could easily have denied the journal its due credit. No explainable excuse whatsoever could justify such an omission on the part of nursing leadership.

The members of public and stakeholders (policy makers included) would be forced to look elsewhere. Perceptions of the NNAK's and KNUN role in the nursing profession may be unclear when one acts like the other. It marginalizes nurses when the only national leadership voice is coming out of unions.

How should nursing in Kenya position itself - more as a profession or as a union? Which one brings food on the table, or it was a matter of survival? – did I hear that? In the view of this author, while KNUN survives (to fight even more battles), NNAK inevitably will become irrelevant. Survival or natural selection/preservation might explain:

> *In the **theory of natural selection alias preservation:** while the strong survived to tell the tale with scars as evidence of the same, the weak perished without a sin attached to their bodies, innocence still running in their veins.*
>
> *[Darwin & Russel, 1859]*

In any case, nurses ought to on top of things, in control and not be dragged into every other press interview. This was often a catch 22 situation. If other people want to discuss nursing issues they can go ahead and do so, we can always make a rejoinder or rebuttal a negative rhetoric. Though "you can't unscramble scrambled eggs" the price of 'damage control' is something we must be ready to bear, its part of the business in media advocacy.

Knowing how to respond to both the message and its credibility as well as pre-empting and counter argument requires preparation (Staples, A. (2009). Weaving a narrative that was believable was important, but being present in a multidisciplinary panel that ended up belittling the profession was worse (in this writer's opinion).

'Learn as much as you can about the issue you are agitating about, have all the statistics available, both at the fingertips and at the tip of your tongue. If there is a science or political philosophy or history involved you should know it well enough to explain it in an understandable

way to the average person' (Community Tool Box; Also see A Policy Brief in Chapter 13)Kingdon (2003) model approach in policy development states that health care advocates must lie in wait for a window of opportunity if they are to be successful in getting their proposed initiatives translated into health care policy. An important problem must be recognized, a viable solution proposed and the problem must have political support. *The research adds a much- needed support for the evidence about the issue. Putting the act together i.e. coalescing the four ingredients then timing* (italics mine), this can be challenge and we may not be that patient. Some bit of testing the waters must be done before *going for the jugular!* There are no shortages of lessons to be learned when this was not done.

The most well-intentioned ideas failed because one or the other may be lacking. Florence Nightingale used coxcomb pie charts during her days and did influence policy in a big way. How would we expect to do better in our days by going for/and with less?

A window of opportunity existed to promote the one year higher diploma programs for both registered nurses and BSNs. It has not been said often enough but it is true that we lack a policy paper that outlines whether or not the diploma will be referred to as Post under-Graduate Diploma (PuGD) for the degree holders and Higher Diploma for holders of basic diploma.

But again they will be in the same class, so? Or can a PG be granted only by a certain institution or does it become one when one had a previous degree? I recall with nostalgia that for a long time, only nurses got an (another) diploma at a post basic level, it seemed the title of a higher diploma was something they neither liked nor deserved. May be the Kenya National Qualifications Framework (Act) 2018 Legal Notice No. 118 was going to streamline these discrepancies once it was effected. A Diploma would be taking 3 years as stipulated in the Act.

Seemingly only nurses could not finish an ordinary diploma in three years but have to go an extra six months. Why indeed? Out there a Diploma is a diploma. Some take 3 to six months, a year, others two. Few diplomas take longer than 2 years. Apparently, this did not matter to many employers (even when institutions of higher learning were the employing authority).

This had created anarchy as was alluded to by no less than then Education Cabinet Secretary Dr. F. Matiang'i in May 2017 when he oversaw the drafting of Kenya Qualifications Framework one of the many *Matang'i reforms* in the education sector. He promised this was going to be effected from January 2018. This was going to be a one stop accreditation, teaching, training, testing, assessment and evaluation services for qualifications and accreditations.

It was a disturbing discovery that some other health sciences programs have had to go for long holidays in order to fit in a 4-year undergraduate program or else because they lacked ?content. One such don admitted 'we can crush this in 2 years!' May be, may be not - it's no wonder the program did not get a single applicant in some of the academic years. As was usual then blame it on the infamous Matiang'i reforms!

The utility value of Higher Diploma and Post Graduate Diploma is not in dispute but we have continued to refer to them as horizontal education. The employers have got the most out of these specializations without commensurate emolument. The nursing fraternity was caught flatfooted with less than the adequate number of specialized nurses in critical care and renal nursing when the government went for starting critical care units and dialysis centres in all the counties, it was all systems go. In 2013, public hospitals had a capacity about of 88 dialysis per day while by 2017 this had increased to 900 per day. During the same period the number of ICUs increased from 2 to more than 11. (Also see The Role of Nursing Education and Collaborative forum for trainers and clinicians here below)

What about the nursing preparation with leadership and management of health systems. Our institutions continue to be run by nurses and doctors who have little or no idea on how to do it. How have we prepared for these positions coming up in the counties?

With all due respect, it could be understood if we let some of these leadership matters rest but this book is about interrogating health systems in resource constrained settings and issues of surrounding nursing leadership matter a lot.

It was not intended that the interrogation would be in a controlled environment but on things as they were. It would not serve posterity or the purpose of writing this book when we choose to engage in selective amnesia on what had gone wrong in the past and fail to learn valuable lessons from it.

17.1.2 Nursing excellence is possible

There is a need for support towards raising the level of performance for nurses in Kenya. "Identify the best person for the role on a deeper level, and that's the person who's going to truly care and make every patient's experience a memorable one." Theresa Mazzaro, supervisor of nurse recruitment and workforce planning consultant at in Fiercehealth *ebook* (2014).

"What we're looking for and what most of my colleagues are also looking for is the right fit - individuals who understand that working in healthcare is not just about money or prestige or title, but whether or not you are truly committed to what we value. When you do find people with the right behaviors, they tended to be high performers, they tend to be open to change, and they tend to be people who really care about the patient," Burnes Bolton in Fiercehealth *ebook (2014)*.

A large section of this chapter has been devoted to the role of nursing education in quality health care delivery. It ends with **Confessions of a hospital administrator** about nursing the reader cannot afford to miss. Professor Gayle Preheim (who was once my teacher) wrote this in one of her bios 'Nursing leadership, practice and education continue to undergo unprecedented change, it's exhausting and exhilarating!' By networking one can learn a lot and get some tips like MAIDET below:

MAIDET

With some networking, one can learn a lot and get some tips. One of my classmates at MSN shared that in their hospital they have MAIDET which stands for **M**anage up, **A**cknowledge, **I**ntroduce yourself, Duration for how long they will stay, Expectations on what will happen during their stay, and **T**hank you for choosing our hospital.

She emphasized "M" for "Manage Up" meant, in essence, to speak highly of the other members of staff, particularly the one to whom the care of the patient is transferred at the end of the shift. ("This is Susan, who will be looking after you now. She is very experienced and will give you excellent care!"). She added, 'I always tried to connect with my patients but find this is quite a successful tool for me. We also are using the 5 feet - 10 feet rule: *At 10 feet away, you smile, and 5 feet you say something'.*

On 9th Aug 2016 J.S. posted this on KNUN wall *….making a serious face to avoid questions from clients does not make you any serious. Relax, smile, help people where you can and refer or consult where you can't…*



'Smile'
(caption courtesy of allnurses.com)

17.2 The Impact of Emerging Technology on Nursing Care

While myriad challenges and forces are changing the face of contemporary healthcare, one could argue that nothing will change the way nursing care is practiced more than advances in technology. Due to this, some issues are not as clear as they used to be.

Indeed, technology was changing the world at an invincible speed and nowhere is this more evident than in healthcare settings (Houston, 2013). Some likely matters that may already be familiar include Email, social media networking, the internet, cellular technology, text messaging, video conferencing, smart phones, telehealth, and telemedicine. According to e.mozilla.org online life is now a combination of desktop, mobile connected device, cloud services, big data and social interactions.

If we consider social media alone, it is said in academia 'publish or perish' like the proverbial "Ivory Tower" this tower might be getting taller and more out-of-touch than ever. Apart from being scientific, it does not seem right for medical academia to shy away from everyday communication: mass media, social media, and observations. As the world is moving in terms of communication so should those who write. I submit that as far as technology is concerned, the nurses, as well as other health care providers, have to "adopt-adapt-or-perish". There is a seemingly accelerated adoption of social media by health care institutions.

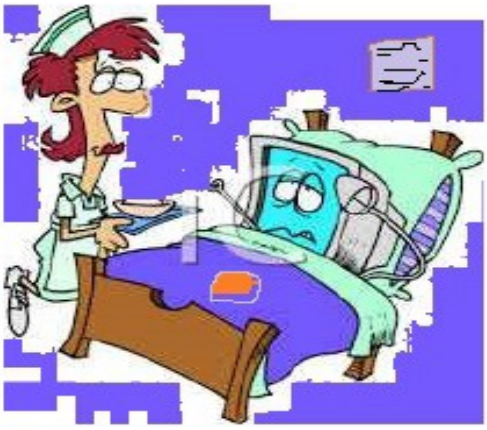
More than 94 percent of the 3,371 hospitals in the US in a study featured in *FierceHealth* December 2014, had Facebook pages and 50 percent had a Twitter account. The study reviewed hospital-related activity on four social media platforms*: Facebook, Twitter, Yelp and Foursquare* (Ilene, 2014; Kamau *et al.,* 2016). Social media platforms give hospitals the ability to respond to patients and collect data in real time, using new portals like Instagram, Pinterest, Digg, StumbleUpon, Snapchat and many that are evolving every day.

There is a likelihood that through the information superhighway consumers will continue to interact with hospitals through social media to exponential levels. From the study just alluded to, most hospital postings on social media provided generic observations or employee-related issues and achievements, which defeated the purpose of the platforms. This author adds that some employees, as well as some disgruntled elements, can pose and post as 'patients' which is most unfortunate. These are matters for weighing and considerations by the nurse now and into the future.

Several emerging human technology interface matters will change the practice of nursing; skills that nurses currently have will need to develop to acquire, use, and integrate these emerging technologies; nurse leaders will need to integrate this new technology. Some of these technologies include Genetics and Genomics, less invasive and more accurate tools for diagnostics and treatment, Robotics, Biometric signatures, Electronic Healthcare Records (EHR), Computerized Physician/Provider Order; Entry (CPOE) and Clinical Decision Support (Houston, 2013; Ministry of Medical Services, 2014).

This calls for specialization in fields such as MS Nursing informatics. This and every other specialty training that meets the demands of the emerging technologies do not exist currently in

the country. According to NNAK agenda 2015 'Nursing specialization is the best vehicle in terms of identity and to be in tandem with the current specialized care, we shall lobby for increased nursing specialties and posting of nurses according to their specialization to guarantee developments of mentors, consultants'.



Pic: The focus is not on the computer directly, but rather how it helps nurses to enter, organize, or retrieve information.(Courtesy of clip developer)

Growth in robotics, for example, is expected due to workforce shortages, a growing elderly population, and a call for higher quality care not subject to human limitations. It is ironical that even with the serious shortage of nurses in our hospitals, anecdotal evidence showed that currently more than 7000 nurses in Kenya are not in service and plans to absorb them remain unclear.

On January 9th, 2015 the first batch of 170 out of a possible 700 health care providers (drawn mainly from newly graduated and jobless professionals) were airlifted to Liberia where they will work under the African Union Support to Ebola in West Africa (ASEOWA)-volunteer program for 9 months in an ongoing government pledge to help fight Ebola Virus disease (EBV). Ebola had killed about 8000 people in 6 months in Liberia, Sierra Leone, and Guinea. It is also worth noting that Kenya donated Kshs 90 million to these needy countries towards the same.



Pic: A poster by the African Union Support to Ebola in West Africa (ASEOWA)

It is against this backdrop that the likelihood that the use of robots as direct service providers could supplement or perhaps replace nursing in the future might appear far-fetched. Genetic advances are likely to eliminate the need for organ transplants since new organs will be able to be grown from a patient's own tissues.



Pic: Nursebotics (Courtesy of Robotics)

Clinical Decision Support Systems will likely be commonplace in the near future. Nurses then will need to have the knowledge, information acquisition and distribution skills (Houston, 2013). These will be competencies that employers will be looking for. These included ability to meet patients' care needs across the generational divide as will be seen below:

The younger generation consisted the largest cohort demographically. Whenever they became patients it was important for nurses to see them for who they were, that they were more discerning. The best evidence so far accessed by this author was explained in the Clinic 20XX report (Eagle, 2017). This US based study: Designing for an Ever Changing Present reported in Health Facilities Magazine as *designing hospitals for the millennial generation*. Millennial required a different hospital design.

There was need to be change ready and future proof while designing health care for an ever changing present and for the future. A need to adapt to and plan for what was going to happen. In a nutshell a clinic today needed to: well branded, have a Wi-Fi, video capabilities, users portals, mobile phone charging outlets, hospitality elements etc. They would like to switch from workstation, to entertainment, to education with ease even when in the hospital.

In the 20XX report, 62% of millennials wanted to have their health needs met as well as have a good experience as they do so. 54% described their phones as their lifelines as opposed to simply tools of communication, and that they would like to use them to access health care services.

Quality of waiting time was important to them and so was connectivity (both virtually and personal) to both technology and other people including friends and family. They preferred either walk in appointments with less than 30 minutes waiting time or same day appointments.

Nanda Upali Ph.D. observed that 'millenials just want more…love higher standards, so we give them clean, efficient, enhanced experience that exceeds expectations'. For example they preferred a care giver who displayed on the computer, reviewed and discussed health information together with them. Their positive experience included having a family doing a hospital stay with them for as long as possible. This meant providing for family needs in the patient's room.

17.3 Leading Change, Advancing Health: IOM report

The IOM report urged nursing leaders to reconceptualize the role of nurses across the care continuum and design new delivery systems enabling them to practice to the full extent of their education and training.

Nursing represents the largest sector of the health professions. Nurses made up the largest cadre comprising over 55% of the Kenya health workforce (Source: WHO Kenya Country Health System Fact Sheet' 2010). They were generally the initial point of contact for the communities with health care services. In the words of Peggi Winter (2015) in her doctoral thesis University of San Francisco, …nurses work across the continuum of care - from labour and delivery for those welcoming new life to hospice care for those coping with end-of-life decisions. Nurses provide prevention and wellness programs for children and healthy adults and care management for seniors with chronic conditions. Nurses are also found in *most* areas of the organization.

According to the Robert Wood Johnson Foundation -RWJF, (2011), nurses are the largest group of healthcare industry workers with the most face-to-face interaction with patients. This presents an opportunity for nurses to take a leading role in shaping and improving the patient care experience. Healthcare reforms taking place in Kenya from 2014 onwards have not been witnessed before on such a large scale. They give nurses new opportunities to deliver care and play an integral role in leading change.

According to the IOM report (2011), nurses have become partners and leaders in improving the delivery of care and the health care system as a whole. Accessible, high-quality care cannot be achieved without exceptional nursing care and leadership. Although it was difficult to prove causation, an emerging body of the literature suggested that quality of care depended to a large degree on nurses. One such assertion by Institute of Medicine (2011) was that to improve quality and access to patient-centred care it would be important to allow nurses to make more care decisions at the point of care.

Many of the quality measures used over the past few years addressed how well nurses were able to do their jobs such as the prevalence of pressure ulcers and falls among other nursing-sensitive care interventions (Kurtzman and Buerhaus, 2008). National Database of Nursing Quality Indicators which had more than 25 percent of hospitals in the US participating documented more than 21 measures of hospital performance linked to the availability and quality of nursing services.

Participating facilities were able to obtain unit-level comparative data, including patient and staffing outcomes, to use for quality improvement purposes. Comparison data were publicly reported, which provided an incentive to improve the quality of care on a continuous basis (Kurtzman and Buerhaus, 2008).

17.3.1 Teamwork

Teamwork and collaboration are critical to seamless high-quality care. The process begins with understanding the roles and responsibilities of each healthcare disciplines. The understanding and the trust it fosters must start when one joins nursing and medical school programs, and continue as a cultural norm in practice settings.

Healthcare's complexities make it difficult to provide comprehensive solutions across all

disciplines. Managers know that collaboration is a key element in handling intricate and ongoing issues and operations in any organization. An expert panel at the Institute of Medicine (IOM) identified working in interdisciplinary teams as one of the five core competencies for all health professionals (IOM, 2003). These growing complexities make it necessary for more interdependence among healthcare professionals.

An interdisciplinary approach enables persons from different disciplines to share unique perspectives to achieve common goals. Thus, it's important to gain a better understanding of factors contributing to interdisciplinary collaborations. It's also important that factors contributing to successful inter-professional collaboration be understood as disciplines work together to achieve common goals. Literature suggests that stronger collaborative relationships across healthcare disciplines are associated with improved patient safety, quality of care, and outcomes (Lumague *et al.,* 2006).

The manager must also understand the impact that inter-professional collaboration has on job satisfaction and team cohesiveness. Healthcare organizations benefit from effective inter-professional collaboration in terms of more efficient work processes, more satisfied healthcare providers, reduced healthcare cost, and greater responsiveness to healthcare needs, which improves the quality of healthcare and patient management outcomes (Lumague et al 2006).

Sharing accurate patient information, medical records, test results, and care plans among others between healthcare professionals are fundamental to coordinated care. Advantages attributed to inter-professional collaboration include collective responsibility or appreciation for the expertise of other team members, improved communication, cultivation and sustainable collegial relationships between partners, and formation of an effective healthcare team (Peterson, 2014).

To be effective in potentially catastrophic situations that saving lives is, multidisciplinary health professionals depend on their mastery of standardized routines and on complexity communication – spirit of collective mindfulness at its best.

Porter-O'Grady & Malloch (2015, p334) described collective mindfulness as the capacity of groups and individuals to be keenly aware of significant details, notice errors in the making, and have a shared expertise and freedom to act on what they notice. They listen intently and with full presence, question for clarification and intervene as a finely tuned unit. The lack of concerted effort and teamwork could be detrimental to the health of the nation including fighting cholera.

Team work skills

Patient safety experts agree that communication and other team work skills are essential for providing quality health care and for preventing and mitigating medical errors (AHRQ http://teamstepps.ahrq.gov/). The nurse must function effectively within nursing and inter-professional teams fostering open communication, mutual respect and shared decision-making to achieve quality patient care. This testimony was shared by a nurse concerning team work.

According to AHRQ, both nurse and physician change champions are important. However, this author observes that in resource-limited settings without physician support the effort is less likely to succeed, they are clearly in control of the milieu since they are the leaders and control resources in health care system.

The following notes were gleaned from Quality and Safety Education in Nursing (QSEN):

Function competently within the scope of practice; Solicit input from team members to enhance own and team performance; empower others to contribute towards betterment of the team performance; Support evidence contributed by others.

Offer leadership and guidance as necessary in collaborative care; Initiate and sustain partnership; Manage overlaps in roles played smoothly; Appreciate different communication styles and differing views; Assert own perspective as necessary as patient's advocate; Acknowledge own strengths and weaknesses, contributions to effective or ineffective team functioning;

Respect the unique attributes that members bring to a team, including variations in professional orientations, competencies; Implement care as agreed upon by the team. Identify barriers to teamwork e.g. by discouraging hands-off approach to patient care if observed among the team or not showing respect to the centrality of patient/family as core members of the health care team.

Communication is a vital part of teamwork. The SBAR is a powerful tool that is used to improve the effectiveness of communication between individuals and teams. SBAR stands for Situation, Background, Assessment, and Recommendation (Response is). The Institute for Healthcare Improvement (IHI) contains useful tool kits on SBAR. http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx.

IHI graciously had made them available for free and focusing on the greater good which is patient safety. These are great for resource-constrained settings. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with each other with a shared set of expectations.

Staff and physicians use SBAR to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy. It is easy to use and can help your staff learn the key components needed to send a complete message! Here is how SBAR works:

• *First*, quickly organize the briefing information in your mind or on paper using the four elements (Situation, Background, Assessment and Recommendation) in sequence. Only the most relevant data is included, and everything irrelevant or of secondary importance is excluded.

• *Second*, present your briefing. Since team members can immediately recognize and understand the familiar, predictable SBAR format, you help them more efficiently and effectively address a situation or solve a problem.

• *Third*, they may confirm, clarify or enhance what you've said, then work with you to take the required action.

SBAR increases overall operational excellence, creates an environment in which a team can work together more effectively and, most important, improves the safety of the patients they serve. One of the ways SBAR does this is by creating a shared mental model that ensures members are on the same page. SBAR also requires you to speak frankly and openly with others, regardless of their position in the organization. SBAR has been found very useful daily on inter-shift/transition handover.

Team redefined: In their book, *The Wisdom of Teams*, Jon R. Katzenbach & Douglas K. Smith define a real team as a small number of people with complementary skillls who are equally committed to a common purpose, goals and working approach for which they hold themselves accountable.

Here are two examples illustrating the components of SBAR: **SBAR Example 1**

The following is an example (using fake names) of admitting nurse call to the primary doctor using SBAR:

> *'This is Muthoni Daisy, ICU nurse Cardiac Care Centre, I am calling from Compleat Healthcare Hospital about your patient Josphat Kiplagat.'*

Situation: Clearly and *briefly* define the situation. For example,

> *'Mr. Kiplagat a readmission had multiple prescriptions of Warfarin, Heparin, and Clexane at various points during his last admission. I am not clear as to which ones he is supposed to take now.'*

Background: Provide clear, relevant background information that relates to the situation. In the example above, you should consider including the patient's diagnosis, the prescribing physicians, and the dates and dosages of the medications.

Assessment: A statement of your professional conclusion.

Recommendation: What do you need from this individual? For example, 'Please clarify which is the correct dose of Coumadin for Mr. Kiplagat to take and how we should carry on managing his anticoagulant therapy?'

SBARR 2

In order to make sure what is meant, said, heard and understood is all the same message use a structured communication such as SBARR. In addition to the SBAR discussed above, there are 2 R's last R stands for Response. SBARR is a structured communication process that delivers key information in a format that catches the listener's attention. It communicates the current situation or status, relevant background information; current assessment of what you think is happening, and your recommendation for resolution or action. The listener is expected or requested to respond

The following is an example of a nurse call to the primary doctor using SBARR:

> *"Dr. Mutai, this is Joan Maina Orthopaedic nurse, I am calling from Compleat Healthcare Hospital about your patient Josephine Awuor."*

Situation

> *"Here's the situation: Mrs Awuor is having increasing dyspnoea and is complaining of chest pain."*

Background

> *"The supporting background information is that she had a total hip replacement two days ago. About two and half hours ago she began complaining of chest pain. Her pulse now is 124 and her blood pressure is 130 over 55. She is restless and short of breath."*

Assessment: *"My assessment of the situation is that she may be having a cardiac event or thrown an embolism."*

Recommendation

"I recommend that you see her immediately and that we start her on O_2 stat. Do you agree?"

The response is:*I need you here right now. When can I expect you?*

The US Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) dedicates a full website offering free tools to enhance team performance in healthcare. Here is another powerful solution to improve patient safety within the organization. It is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals: http://teamstepps.ahrq.gov/. TeamSTEPPS is the result of over 25 years of research and development, with core components of leadership, communication, mutual support, and situation monitoring. TeamSTEPPS provides higher quality, safer patient care by:

- Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.
- Increasing team awareness and clarifying team roles and responsibilities.
- Resolving conflicts and improving information sharing.
- Eliminating barriers to quality and safety.

This author recommends to the readers to familiarize themselves by first getting a quick, then a comprehensive overview of TeamSTEPPS (it has been mentioned in various contexts in this book). If you have interest and time permits, take a look at the *Tools and Resources and also Implementation Stories*. This will give you ideas for relevant to your professional work setting, role, and communication goals.

It is also good to state here that even within nursing fraternity we are still talking about a team. The great thing about nursing is that you are an individual within a team, as a nurse you still very well be successful and influential member of your team and also collaboratively.

Though often working collaboratively, nursing does not "assist" medicine or other fields. Nursing operates independent of, not auxiliary to, medicine and other disciplines. Sometimes one wonders if the word collaboration exists in other disciplines as much as it does in nursing.

For instance, a chief medical officer interviewed in (Khoury et al., 2011 Gallup study) had done a literature search of the term ''collaboration.'' He asserted that all such references were in the nursing literature and none in the physician literature. Could this be the problem, so that collaboration is not emphasized in other disciplines? This might be creating a lot of barriers for those trying to reach out.

Nurses' roles ranged from direct patient care and case management to establishing nursing practice standards, developing quality assurance procedures, and directing complex nursing care systems (American Association of Colleges of Nursing- Fact Sheet).

May be that is what Boyle (2011) had in mind when she stated, "As a clinical nurse specialist, I poignantly and repeatedly counter any depiction of my practice as being an extension of a physician or a mid-level anything. I am a nurse with a distinct set of skills and a hard-won, highly specialized graduate degree, and proud of it. Don't ever call me anything but a nurse".

A vital part of leadership role in the new age of health care involves working through the differences between professionals and building mutuality as a basis for preventing unnecessary conflict and resolving unavoidable conflict when it arises. Team based and continuum driven approaches to service place a great deal of emphasis on who people are rather than simply what they do (Caspers & Pickard, 2013). In times of rapid change, stress levels escalate, conflicts rise, and people's ability to collaborate breaks down.

That's bad news for quality patient care, safety, and satisfaction, and it could be bad news for an organization's very survival. Right now we need employees to be fully engaged and zeroed in on

SBAR should be used when giving patient information between primary caregivers regardless of discipline.

The pertinent information that can be included will fit in the four elements of the S-B-A-R.

Situation is a brief description of the most recent clinical updates of the patient status, for example, a most recent procedure or test done, current condition of patient, the most recent medication given prior to transfer.

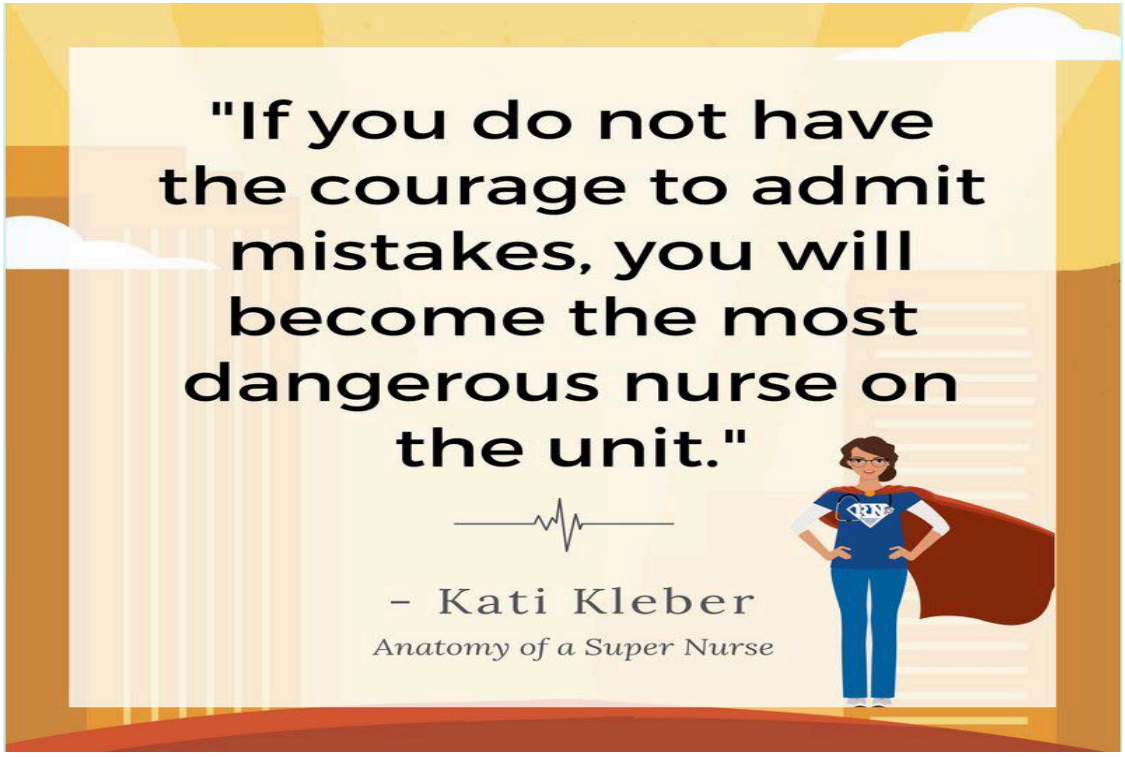
Background is any information regarding familial or medical history of the patient that is pertinent to current care and patient condition.

Assessment is the information on the latest findings that reflect the most recent clinical status of the patient, that is, vital signs, blood test levels, devices, appliances, equipment that is being used, current mental state etc. The staff that is taking care of the patient must review the information with the other staff that will continue giving the care.

Recommendation is the information for future activities, assessment or monitoring of the patient, for example, the frequency of vital signs, any monitoring to be done or discharge plan.

The use of S-B-A-R is convenient and systematic. It is clear and simple. It should be used in all situations and all aspects of patient care.

(Source: AMREF RN- Bsc.Nursing upgrading Notes, Unit 6 on *Fundamentals of Nursing*) authored by Jostine Mutinda



Mural: Anatomy of the super nurse [Courtesy of Kati Kleber]

working together to get patients well and keep them happy. We simply can't afford a culture of conflict. But disputes are bound to happen. Throw in stress and the high stakes nature of healthcare and you can guarantee that conflicts will arise. The good news is that we can learn the skills to resolve conflicts and strengthen our organizations while we do it!

A variety of resources were available on conflict resolution. It may not be as simple as ABC of crucial conversations where:

- Agree. Agree when you share views;
- Build. If others leave something out, agree where you share views, then build;
- Compare. When you do differ significantly, don't suggest others are wrong.

Compare your two views. Some work specific to health care has been done. The Exchange Strategy for Managing Conflict in Healthcare was done by Steven Dinkin, Barbara Filner, Lisa Maxwell (2012). Here are five tips for managing conflict from The Exchange Strategy:

1- Respond,don'treact. Put a pause between action and reaction, especially an emotional reaction!

2 –Choosetherightleader. Make sure the parties aren't 'infantilized' by a leader who's too far above them.

3 – Listen. Ask an open-ended question, and then stop. It can be as simple as, 'So, tell me, what's going on?' You'll know it's time to insert yourself again when the discussion turns negative.

4 –Useandencouragepositivelanguage. Think before you speak. Use positive, easy-to-understand language. And remember, it's a conversation, not a trial!

5 – Buildtrust. Trust can't be demanded. Be sure to ask how each party is affected by the conflict, and, secondly, what each person really needs.

17.3 What roles can nursing assume? Some begging questions

- What roles can nursing assume to address;
- The increasing demand for safe, high-quality, and effective health care services?
- Nursing challenges existing in the management of chronic conditions, primary care (including care coordination and transitional care), prevention and wellness, and the prevention of adverse events (such as hospital-acquired infections)?
- The increasing demand on nursing for better provision of mental health services, school health services, long-term care, and palliative care including end-of-life care? (Institute of Medicine, 2011).
- Much of health care comes down to what value nurses represent relative to other players in the system. As a profession, we need to get in the game and be better at validating all the incredible work we do. We need to be sure the quality data shows our collective value to patient outcomes. Nursing is a service and nurses are vital revenue generators. Economic invisibility of nurses will not do any more.
- Nursing was generally considered a "cost" rather than revenue in a hospital context, which makes nursing a constant target for cost reductions.

Conventionally nursing services fixed salaries provide poor incentives to exert effort. Hourly rates could be better but may be, only may be. At best care is billed together with the room and hospital services (much like an expense) rather than a specific care provider fee based on nursing intensity (plus direct and indirect nursing service).

The payment system must more accurately represent nursing care. This would serve as an incentive to the nurses to give better care. Institutions would see the need to hire more to sustain the same or better care (Welton, 2006). John Welton contributing to policies and politics in health care forum proposed how this could be done an article - *Paying for Nursing Care in Hospitals.*

D There are already measures used to rate the provider's performance used elsewhere in the world and nurse could stand to gain a lot if it were to be implemented. This ought to be cost effective either way. Nurses ought to bill and be reimbursed for the service they provided. Today, in response to variations in the quality of health care and rising health care costs, many policy makers and purchasers of health care services are exploring and promoting pay-for-performance (P4P) or value-based purchasing (VBP) systems. The American Nurses Association (ANA) had guidelines on the same.



A mural depicting the invaluable role of nursing (Courtesy of Scrubmag.com)

Nursing brings to the future a steadfast commitment to patient care, improved safety and quality, and better outcomes. Nursing inherently has traditional and current strengths of the profession in such areas as care coordination, health promotion, and quality improvement. Health care reforms provide opportunities for the profession to meet the demand for safe, high-quality, patient-centred, and equitable health care services.

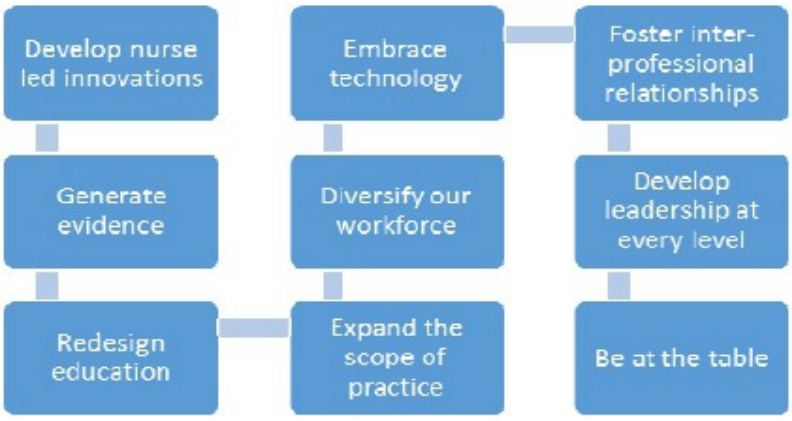
IOM believed that nurses have key roles to play as team members and leaders for a reformed and better-integrated, patient-centred health care system. It assumed that nursing could fill new and expanded roles in a redesigned health care system (Institute of Medicine, 2011).

According to Hassmiller (2010), there were nine challenges that individual nurses and the nursing profession must address if we are to help lead a healthcare system that was more equitable and provided a higher quality of care. This chapter has in a fairly loose manner tried to address some of these challenges (See **flowchart** below):

To take advantage of these opportunities, however, nurses must be allowed to practice in accordance with their professional training, and the education they receive must better prepare them to deliver patient-centred, equitable, safe, high-quality health care services. Additionally, they must engage with other health care professionals through positive partnership to deliver efficient and effective care and assume leadership roles in the redesign of the health care system.

As nurses become more expensive to hire and maintain employers will need to rethink how they use their nurses; working conditions and approaches to increase nurses' productivity. They will need to use them in higher skilled tasks and delegate certain housekeeping and other tasks currently performed by nurses to less trained personnel. Higher wages and new roles would make nursing a more attractive profession (Feldstein, 2011; pp327).

Flowchart on Nurse's role in reforming healthcare



(Adapted from Hassmiller, S. (2010). Nurses role in healthcare reform. *American Nurse Today*. *5*(9): 68-69 www.AmericanNurseToday.com).

This sort of awareness would require changes in nursing scopes of practice, advances in the education of nurses across all levels, improvements in the practice of nursing across the continuum of care, transformation in the utilization of nurses across settings, and leadership at all levels so nurses can be deployed effectively and appropriately as partners in the health care team.

In addition, ensure that the nursing workforce has the necessary capacity, in terms of numbers, skills, and competence, to meet the present and future health care needs of the

public. These were recommendations for an action-oriented blueprint for the future of nursing, including changes in public and institutional policies at the national, state, and local levels (Institute of Medicine, 2011).



Charging for nursing care (Courtesy of the clip developer)

According to AHRQ available at (http://teamstepps.ahrq.gov/), change may involve giving people freedom and discretion, encouraging risk taking and speaking up, giving permission to find team-driven solutions.

The United States passed Legislation in March 2010 which would provide insurance coverage for more Americans. The 'Obama Care' Affordable Care Act 2010 officially called the Patient Protection and Affordable Care Act (PPACA) is a US law that reformed both the healthcare and health insurance industries in America. It mandated that everyone who could afford to must obtain health insurance by 2014 or get an exemption, or pay a penalty.

The law increased the quality, availability, and affordability of private and public health insurance to over 44 million uninsured Americans through its many provisions which included new regulations, taxes, mandates, and subsidies. Such laws had the opportunity of transforming the (US) health care system to provide seamless, affordable, quality care that was accessible to all, patient centred, evidence based and led to improved health outcomes. Achieving this transformation required remodelling many aspects of the health care system; this was especially true for the nursing profession.

Delegation

To help nurses it would be important to think outside the box in the area of delegation. Applying some of the principles of delegation or even outsourcing strategies that were rarely mentioned by most sources include: why should the nurse delegate? When delegating tasks to others goes from being helpful to beingnecessary.

As a nurse, start to think about the things that you don't have to do yourself. If possible, start with the things you least enjoy doing. I believe there is a whole list that nurses could come up with. Kamau (2014) conclusion in an inventory study into the nurse manager's job description '…offered an even wider scope with seemingly never-ending expectations on the nurse manager. This ironically left the nurse manager with 'no job' description so to speak'. May be this was because their job was difficult to describe.

Start to think about things you could potentially delegate. If it potentially will take somebody else less time, save you from headaches and the stress than if you did it - delegate it. Ultimately, if it will cost you less to delegate than doing all the work yourself - take the plunge, delegate it! Do not be surprised if you discover later on that this was one of the best decisions you ever made. The best fit of a delegate

would be to get one who was a clone of self which was not practical. Nevertheless, a best case scenario could be the satisfaction one got when they did not have to do the task all over again after delegating. The more specific the directives and the more empowered your team to function independently, so much the better.

It is not true that someone else cannot be trusted or become experienced in some perceived routine, mundane 'nursing and non-nursing' tasks that essentially drains the nurse's energy and time leaving less and less time for professional therapeutic nursing care. Nurses had taken it as a badge of honour to be jack of all trades 'you know the nurse is blah blah… the backbone of the health system'. Remember they too have a back that tends to ache terribly as a result. To keep your sanity and livelihood, setting boundaries and restraints is a must. Why should the nurse do unnecessary work, so many hours a week when they could work less and be just as productive, if not more? Turbulence was covered in Chapter 1,

Nurse as fulcrum is covered elsewhere in this chapter.

The IOM report 2011 offered recommendations that would collectively serve as a blueprint to a possibility of strengthening the largest component of the health care workforce - nurses by:

(1) Ensuring that nurses could practice to the full extent of their education and training,
(2) Improving nursing education,
(3) providing opportunities for nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts, and
(4) Improving data collection for workforce planning and policy making.

Donna Algase (2013) an editor for Research and Theory for Nursing Practice: An International Journal shared her experience being nursed herself, '... in my nursing heart of hearts, I know it could be even more spectacular and effective if the nurses actually were "all that they could be."' She also alluded to the Institute of Medicine (IOM) report on the future of nursing that advocated that nurses be prepared to take more of a leadership role in designing and delivering health care in an inter-professional model.

According to Dickson & Flynn (2010), the nursing profession could influence policy development because it had (a) the capacity of science to produce evidence (b) the political savvy to use the evidence, and (c) the numbers to ensure that their perspective was heard. Nurses were the biggest factor in providing better care, this was according to FierceHealth *eBook* (2014) entitled 'How Hiring Right (Or Wrong) Has a Direct Impact on Clinical Outcomes'.

The *e*Book examines top nurse staffing challenges and how to overcome them. It also noted that when experienced nurses leave, hospitals must hire less experienced or temporary contract nurses, leading to poor patient outcomes. Nursing staffing issues have been covered elsewhere.

So far it is my hope that nothing exceeds the passion for ensuring that the individual care provider (in this case the nurse) does not fall through the cracks as we expand on the views. The individual care provider one moving target managers of health care in Kenya must keep an eye on. That is why I would propose that our health care systems adopt strengths-based approach in management. In a nutshell 'The Basics of a Strengths-Based Management Approach' according to Burger, Hoogerhuis and Standish (2014) include:

- Understanding and appreciating each employee's unique talents. Appreciation is the expected currency for doing a job well. To build an engaged and optimized team, managers first need to discover each person's talents, style, goals, needs, and motivations.
- Identifying the tasks and activities that each person does best. With an understanding of what each employee does best, managers can use individual contributions to building a stronger team. Emphasis is going into an outcome-

based health care system. It is more of effectiveness and not just efficiency (see **Campus siege** below).

Help employees understand, appreciate and invest in their unique talents. The better the managers do these the more they can help employees apply their dominant talents, and the greater each person's and the team's potential will be to consistently act with confidence, direction, and excellence.

According to Gallup Report entitled '*Managing for strengths'*: Employees who used their strengths every day were six times more likely to be engaged in their jobs (early, continually and throughout) and their engagement level affects how they care for patients. Employees unite as a team, everyone has their talent and their focus area, and all employees know how they contribute to the team to meet a clear and compelling performance goal.

There is this utopian thinking that crossed my mind as I internalized the managing for strengths concept: - There is no better way to find good staff than networking. Therefore it is possible to say then there be no better and more concrete networks than the networks that are built through collaborations. I know companies that bring together such talents, bringing in independent contributions to joint efforts. They are hubs of success. There are people who come together to create empires. How about making this a culture in everyday life in the workplace?

Employees have a better understanding of one another, are more collaborative and intentionally structure tasks and responsibilities to maximize the team's talents, utilizing paths of least resistance. Leaders and employees identify by the "the end of the game" who could manoeuvre what best (Burger *et al.,* 2014). When one gets involved in something that they feel they can make a difference it can mean so much to them as well as to those they serve. "We go out of our way to spotlight people who go above and beyond their job description and really call out the truly amazing caregivers that we have," Theresa Mazzaro in Fiercehealth *ebook* (2014).

Clearly, among the factors that helped providers to be optimally productive, clear performance expectations set forth in an accurate and up-to-date job description are important starting points. Daniel Ndambuki alias *Churchill* one of the most inspiring personalities and comedian in Kenya today pointed this out '… keep on doing what you are good at and with time everything will take care of itself…. Do it and go home saying there is no job like it?' Celebrities were useful in running voice overs in *jua-jijue-jipange* Maisha (paraphrase from Swahili for: get information, know your status, plan your life) HIV/AIDS campaign.

Considering how emotional elements affected patient experience, this finding by the *Gallup Consultants* was uniquely significant to leaders in healthcare. Jeff Burger, a Managing Consultant at *Gallup* asserted that managers who made strengths the backbone of their management approach could tap into employees' innate power and potential, helping them improve speed and productivity, resilience and growth, longevity and attendance, and innovation and precision.

Working from their strengths also could help increase employees' passion for their work. Across all departments and roles, strengths-based management helped build teams that performed optimally and contributed to better patient experiences.

I want to add here that it is not just about talent but people with a great attitude and were hard workers. Even in the music industry, many admit that talent accounted for 15% or less in terms of success. Stephen King might have observed this when he said, "Talent is cheaper than table salt. What separates the talented individual from the successful one is a lot of hard work."

Porter O'Grady and Malloch (2015) added that what is needed in health care is time for reflection and contemplation of ideas and issues. Experts agree that pay is not the chief motivator for productivity, but in general, employees desire to do meaningful work most of all, next they desire opportunities for collaboration through group decision making, then they want equitable pay. All human beings have a need to express their uniqueness and their talents in the work they do and be recognized for their contributions.

Oprah Winfrey was quoted saying that *"the way to make people happy is to find out what they want by asking them ..."* She added. It would be unfortunate to assume that you know what people want and how they want it without asking them to give you specifications. *"Feel the power that comes from focusing on what excites them."* Oprah is an influential book critic, an Academy Award-nominated actress, and a magazine publisher. She was ranked for 3 straight years the most philanthropic African American of all time. Here is one last quote from Oprah: "Doing the best at this moment puts you in the best place for the next moment." Don't waste those moments.

According to Standards of Nursing and Practice for Nurses in Kenya (NCK, 2012), the nursing profession (education and practice) in Kenya is geared towards Constitution of Kenya 2011, the nurses (Amendment) Act 2011 that have impact on health care delivery; An enlightened clientele with ever increasing demand, technological and scientific advancement in quality nursing care; Expanding roles of the nurse globally; aspirations to meet the Kenya Vision 2030, Sustainable Development Goals(SDG's), Agenda Africa 2063; and local, regional and global development blueprints. Health care also continues to shift beyond the hospital to more community-based primary care and other outpatient sites.

Campus Siege

A group of 4 gunmen members of Al-Shabab terrorists attacked Garissa University College on 2nd of April, 2015 and senselessly killed 147people (142 students and 5 members of the disciplined forces), 104 injured (91 of them critically). The gunmen had engaged policemen and Kenya Defence Force (KDF) in a standoff for more than 9 hours. Although KDF responded swiftly they were clueless on how to handle the situation as the wanton killings continued inside the campus.

It took the Recce Squad commandos less than 17 minutes in a sting operation to neutralize and end the siege. The combined effort rescued over 500 students. It was alleged that the Recce Squad came by road for the 6 hours journey that would have taken 45 minutes by air. All this time 4 helicopters were neatly packed at Garissa Airstrip, some from 10 am (2 belonging to local politicians, one had come with the Cabinet Secretary and the other one with the Inspector of Police. It took several hours for a chartered plane to come from Nairobi to evacuate the critically injured for further medical treatment.

It was alleged in Parliament in a debate that followed that the designated plane was not at hand to ferry them although they had set out at dawn for the offensive. Only 4 out of 11 Police Air wing planes were operational. Ironically, the Cabinet Secretary Internal Security and Inspector General of Police had been flown in several hours earlier. Each of the Recce Commandos was paid Ksh500 as Lunch Allowance. The tragedy attracted a lot of reactions worldwide and trending on social media overflow in response to how the situation was handled.

In an interview, later on, the Principal of the College said that although they had been on high alert for some time and requested for something to be done about university security, nuances on a possible terrorist attack that day were treated as April 1st 'Fool's Day' pranks by many.

As to why the attack happened despite clear warnings (which were treated with a dismissive attitude) remains a begging question. Since then, public servants including teachers and health care providers have fled the region, aggravating an already resource-constrained health care setting.

Source: [Motion For Adjournment Under S.O. 33(1) Garissa University College Terrorist Attack. Kenya Parliament Proceedings, Debate 14th April 2015, *The Hansard*, Electronic Version, Supplemented by *"Children of a Lesser God."*]

Kenya was generally an early adopter of different policies, and interventions meant to improve health services. As a result, many highly effective interventions have been introduced, affecting health outcomes (Kenya - Situation Analysis, 2012). However, the achievement of health outcomes on the level of health impact is significantly affected by a number of contextual factors such as high population annual growth rate of 2.4%.

The population of 39.4 million people (2010 census, KDHS, 2010), half of them below 15years of age, inequitable distribution of resources with a wide gap between the rich and the poor, women empowerment and generally gender disparities still continue to be an issue, literacy levels disparities whereby Nairobi was 78% while Marsabit 4%, security concerns with areas in the North being worst hit by inter-clan rivalries, cattle rustling, and the sporadic terrorist attacks.

These will mean that health care will continue to shift beyond the hospital to more community- based primary care and other outpatient sites. All these do have a bearing on nursing as a career with difficult personal and overarching choices to be made.

According to a presentation by the Chief Nursing Officer in Ministry of Health Kenya, Mr Chris Rakuom (2014) to a Moi Teaching & Referral Hospital's nursing workshop on the nursing process, nursing is a service and as a service: People seek it and nurses provide it.

It must be available, accessible, qualitative, and acceptable. He outlined The Vision of Nursing in Kenya to: Achieve high-quality nursing and midwifery services which are accessible and acceptable to populations and are being delivered by empowered nurses. Everything we do is intended to:

- Improve the quality of nursing care/services.
- Improve client/patient acceptability of our work.
- Increase clients/patients responsiveness – the demand for services.
- Improve the health status of our people.
- Contribute to improvement of citizens' quality of life (QoL).

(Source: Chief Nursing Officer Ministry of Health, 2014)

Nursing had continued functioning as a department in the various organograms. Sometimes as the thinnest of the thinnest directorates portfolio-wise and in terms of authority. Main examples included the Ministry of Health headquarters and subsequently at county levels.

A classical case in point used to be in one level six Hospital (name withheld). In the later algorithm, the Hospital Chief Nurse docket fell under the Assistant Deputy Director of Clinical Services (ADDCS). This in effect meant that nursing was somewhere on the 4th or 5th rung from the top in terms of policy and decision making (Kamau 2012). Nursing needs a louder voice.

Nursing, therefore, cannot be just a department like any other, world over this anomaly has been rectified. This apparently meant that the nurse was not empowered enough nor was he/she well represented in decision-making at policy making level.

I highly doubt or rather cannot be too sure the situation has changed much. In a lot of organizations that have maintained the status quo, it's hard to justify to them, but once you look at patient management outcomes, patient satisfaction and quality outcomes and the trend the world over, you can see it pays off.

Patient satisfaction has a reciprocal effect, meaning it can be used to improve nursing care that will in turn increase satisfaction. Therefore it's an important indicator of quality nursing care. But then, did it also imply that that being patient with patients who were not patient meant the nurse was expected to be on the receiving end and to put up with everything?

The approved Revised Scheme of Service for Nurses, 2014 provides for establishing a Directorate of Nursing Services in the Ministry of Health organogram but is yet to be realized as opposition to this move in favour of the status quo remains at an all-time high.

The scheme of service, for example, would have addressed stagnation, promotion and re-designation challenges. The following is an excerpt from the chair NNAK Agenda 2015 'The year gone-by might have shown grim state of affairs within the nursing profession with stories of leadership wrangles, failure to absorb the economic stimulus program (ESPs) nurses, failure to implement the scheme of service, failure to finalize the Collective Bargaining Agreement, unproductive strikes never ceasing to seize the headlines'.

According to the scheme "Nursing" means nursing and midwifery practices. Nursing functions entail both operational and administrative/ leadership functions. It defined a nurse manager as one who performs the duties of management and administration of nursing or health services and has been trained in management or leadership.

The Nurse Manager is given the responsibility to accomplish specified goals for the organization they work for. The manager must communicate a strong belief in the nursing team's contributions towards the goals of the organization, a belief that with a strong will they can soar great heights.

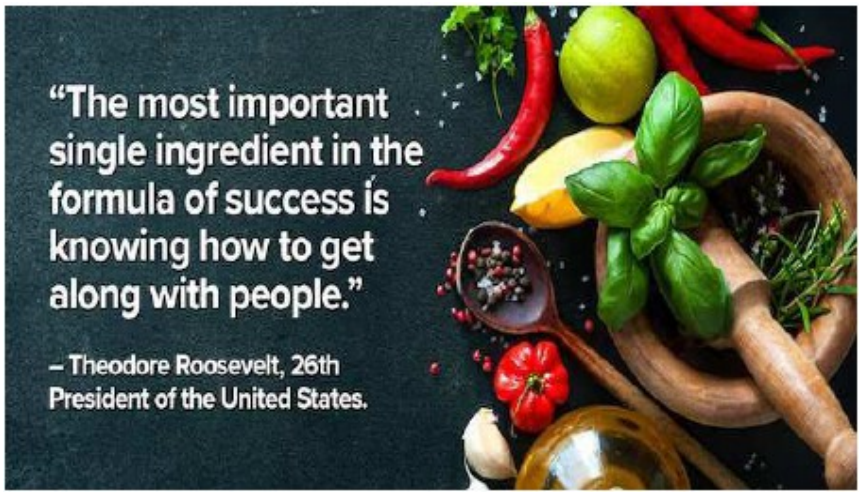
Nurse leaders need management and leadership skills to guide nursing through the current and future tumult of health care challenges and achieve desired goals. The nurse manager had many varied formal and informal roles, which involve team building, decision-making, communication, negotiation, delegation, and mentorship among others (Jones, 2007).

There was need for nursing leadership to find (discover) people who are driving change in their local setting and the health sector but more so within the nursing fraternity; support them, benchmark, pick on best practices and encourage others to be proactive in bringing change to the society. My take - hospital leaders (including nurse leaders) do not need to fix such nurses; they need to get out of their way. Such nurses were inherently self-motivated, highly intelligent, and networked, life-long leaders. In Khoury *et al.,* (2011) Gallup study interviewed respondents argued that if nurses were to become leaders, they should be recruited for their leadership potential, not simply traditional nursing skills. They concluded:

Many nurses were not prepared to assume and thrive in leadership positions because of a lack of formal management training. Nurses needed to develop basic management and problem-solving skills. Leadership skills must be learned and mastered over time.

Potential leaders must be recruited, identified, and developed. Nursing training and education programs must be developed to address skill and knowledge needs of management disciplines.

Experts believe that Emotional intelligence (EI) is the job skill of the future. EI ought to be the in thing for nursing leadership (Porter O'Grady & Malloch, 2015). At the most basic level, EI is about "people skills or interpersonal skills". At more fully developed levels, EI is a determinant of effective and ineffective leadership. EI is about abilities to deal with our emotions and emotions of others.



In doing so, our perceptions help guide our thoughts, actions, and decisions. As Porter-O'Grady & Malloch point out, gaining competency in EI takes time, effort, and practice. EI elements are tied to higher levels of leadership performance, and indicate a strong preference for:

• Participatory management

• Collegial and respectful interactions that put people at ease, encourage, motivate, and recognize

• Ability to self-assess, being aware of one's own strengths and weaknesses to increase consistency

• Illusion of control, steadfastness during crisis, maintaining optimism

• Relationship-building skills, genuinely caring about individuals

• Self-directedness, ability to stay the course, be focused, persistent

• Action-orientation, decisiveness

Selfcare

• Accountability, assertiveness, and directness in confronting problems, fairness

Leadership is about aligning individuals, influencing mutual goal setting and creating

possibilities through facilitation of key strategies. Leadership is change mastery. There is growing evidence in the literature and in success stories that EI is increasingly recognized as significant (Dainton & Zelly, 2015). Organizations that seek to improve a culture of safety, provide patient-centred care, and demonstrate the forces of Magnetism recognize the power of EI. These leaders in these organizations emphasize the bullets above.

The Human Resource for Health Strategic Plan (HRH) for Kenya 2009-2012 pointed out that Leadership and Management training was “missing” from the health sector available.

There appeared to be some concerted efforts borne out of some unknown fear from some quarters that nurses must not be allowed to rise above a certain limit. They must not be allowed to shine, that they must not run the show, a kind of premeditated moratorium. The rivalry has not helped to ease things up for the nurses because medical doctors have by default been the managers of Kenya’s health care systems. May be they are afraid that nurses might become "sage on the stage", rather than the "guide on the side".

Yes, We Can!
Can a nurse become the Cabinet Secretary Health? YES.
Can a nurse become the Surgeon General? YES
Can a nurse become the Medical Superintendent? YES
Can a nurse become the Director of a national hospital? YES
County Chief Officer of Health? YES
Nurses deserved more space in decision making.

The Health Bill 2015 (now Health Act) (got the president’s assent in mid 2017) is an act of Parliament to establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care service and health care service providers, health products, and health technologies and for connected purposes.

The entire devolved health sector required a restructuring process. However, National Nurses association of Kenya (NNAK) took issue with several clauses in the Health Bill. The association alleged that the act had failed to recognize nursing as a profession. It therefore sought to have a stay in its execution by petitioning some of some of its constitutional interpretation and referencing.

There was no denying that the MBChB was perhaps one of the longest, most rigorous course in the world but that did not mean that it had the entitlement to own the entire health system.

Historically, in Kenya, doctors have been in management and leadership positions, resulting in tension with nurses, clinical officers, and pharmacists who typically are not promoted into these positions.

Yet the Health Bill, 2014 (which got the president's assent in mid 2017) once again put MBChB (a basic medicine and surgery degree) as the qualifications of a county director of health (CDH). One Dr. SK, a Public health specialist commented on the matter:

> *I take issue with comment on the minimum requirements for county director of health. My take is we go for the best and broad knowledge base similar to the qualifications of a director of medical services. The county government deserve the highest qualification and deviating from basic degree of MBChB dilutes the noble role of CDH. MPH should be mandatory qualification and be registered public health specialist* (Online comment to CIC website Monday, 27 October 2014). CIC acronym stood for now defunct Commission on Implementation of the Constitution.

In a rejoinder GY on Monday, 13 October 2014 15:13Hrs wrote:

> *I have issues with the minimum qualifications requirement for County Director of Health. You do not need to have a medical degree to manage County Health systems. This requirement locks out good managers who have necessary skills to contribute towards development of health sector at the County level. In my opinion, Article 19 '(2) should read as follows: A person appointed a County Director of health shall-(a) be registered by the Medical Practitioners and Dentists Board; Nursing Council, or ... (b) be at least a holder of a Master's degree in public health, medicine or any other health-related discipline; and (c) have at least five (5) years' experience in management of health services.*

KM on Monday, 29 September 2014 20:48 reiterated

> *'I have disagreed with… the attempt to lock managerial positions of health facilities to some particular health professional … in the 1st Schedule. In my opinion, we should leave the qualifications of the in-charges open. The best option is to allow the facility management teams to propose names for appointment to the Cabinet secretary. The insinuation that nurses, clinical officers and pharmacists, lab technologists, medical biochemists, radiographers and the like have no managerial capacity is insulting.*

Several authors have expressed the same similar sentiments, one is that nurses should be the ones to define and explain their role and focus to the public and that medicine (really healthcare delivery) is strongly represented by a powerful group - doctors. An element of a power struggle has to be acknowledged.

I agree that nursing is a separate profession from medicine, but there is certainly a wide overlap. At the risk of being labelled 'double speak,' I feel nurses need to have support from the doctors and vice versa by providing added value to each other in a non-threatening

way.

The Task Sharing Guidelines, 2017 launched by the Ministry of Health forbid nongraduate clinicians from performing surgeries e.g. caesarean sections, hernias, amputations, post-mortems etc. This apparently is an extension of infighting that has been.

Doctors had been opposed to degrees in clinical medicine and surgery and insisted it is referred to as bachelor of clinical medicine. Historically there was a resistance of doctors to clinical officers and nurses having private practice as documented by historian John Iliffe (1998).

The confrontation has been tried and it has not been the perfect solution so far. My best guess is that there ought to be a middle ground somewhere that nurses can fit and offer focused leadership. The great thing about nursing is that you are an individual within a team.

Though your leader may lack great managerial skills (and this has happened in several instances) as a nurse you can still very well be successful and influential within a team by stepping in. But this is not enough. Wherever nurses have been allowed to lead, they did it well, so no need to fear. In the workplace, the way to go about it ought not to be by minimizing their own role while exaggerating the role of others.

It was commonplace to find a newly qualified Medical Officer; hardly 2 years in the service become the boss of the district health care services or a Sub/County Hospital. What incentives would such an officer need to donate that power and authority vested in them? Transitioning from medical school to being the decision maker was itself an overwhelming and confusing experience as some admitted.

The position of medical superintendent or district medical officer of health (DMOH) and by extension hierarchies in the hospital management team were powerful. Previously (before advent of devolution) there was a fair amount of hospital autonomy with reduced direct government control over public hospitals in the day-to-day decision making.

There was need to deconstruct the social order that elevated the AIE holder as one with largesse at his disposal (held *the yam and the knife* as Nobel laureate the late Chinua Achebe used to say). What with the bonuses, authority to incur expenditure (AIE) that came with the perk. An AIE holder of a public office in Kenya typically had the sensation of a 'lucrative' position since one was in control of finance, procurement, allocation of resources and audit.

In other words the autonomy allowed flexibility for hospitals to use user fee revenues in line with their submitted budgets. It was unfortunate that with devolution this deconstruction in the case of hospital autonomy was overdiluted to the extent that few individuals were interested in becoming medical superintendents. One county hospital in Kilifi had this position vacant for over 2 years although it kept on being advertised (Barasa *et al.,* 2017).

I submit here that there was more required in managing health care services than any basic qualification a health care provider might have. Mark Sanborn a recognized speaker on leadership was quoted saying, 'Being a leader does not require a Title and having a Title does not make you one'.

There is a philosophy that all professionals are "leaders" regardless of where they might fit into the organizational chart, this was emphasized by Steve Adubato in http://www.stand-deliver.com, an executive leadership coach theme in a seminar 'Why the Status Quo Just Isn't Good Enough: Leading Change in Challenging Times'. On 9th March 2015, MK posted **Yes We Can**! On KNUN wall, in that it was preferable to have naivety about 'we can' rather than lots of

intellect about how it could not be done.

These are administrative/management positions in charge of a system and not a cadre of staff. It has little to do with whether one is a medical doctor or not. Some countries have recognized the critical role and the difference a nurse occupying such a position can make. If the military can recognize that, against the stereotype of titles, ranks and even gender, then it is about time Kenya thought the same way. Crossing ranks is normal, it is not a new discovery nor will anyone be doing them a favour.

Health care professionals need to understand the law making process, which does not end when a bill is passed into law. Amendments should be thought out on day one after passage of the bill into law. It is critical that measures are put into practice in such a way that issues are addressed when needed before mere inconveniences become insurmountable obstacles.

(The following textbox amplifies that it takes not just a transparent system but the need to recognize people for who they are and not what they are, See **Just do it!** below)

Just do it!

Lt. Gen. Patricia D. Horoho, was the first nurse and the first woman appointed, became the Army's 43rd Surgeon General Dec. 7, 2011, in a ceremony at Joint Base Myer-Henderson Hall. Please see link http://www.army.mil/article/70556/.

As Army Surgeon General, she directs the third-largest healthcare system in the United States, behind the Department of Veterans Affairs and the Hospital Corporation of America. Further development, the Trump administration removed Vivek Murthy, MD, on April 21, 2017, from his position as surgeon general in the middle of his 4-year term. His replacement was Sylvia Trent-Adams, RN, Ph.D., formerly the deputy surgeon general.

The Surgeon General operates an annual budget of $13.5 billion (an equivalent of Ksh 1.23 Trillion, NB.One of the largest budget Kenya read was the 2014/15 of 1.7Trillion. The health sector was allocated Ksh47.4 billion out of which Ksh2.4billion would pay health worker's salaries). In the 2015/16 FY 2 Trillion budget, the Health sector in Kenya would receive Sh60.8 billion. Some Sh31.4 billion towards development which includes rehabilitation of hospitals across the country. An allocation of Sh500 million to buy more cancer equipment at the Kenyatta National Hospital and Moi Teaching and Referral Hospital has been provided for.

The US Surgeon General manages more than 480 facilities and 29 executive agencies, many of which lead ground breaking research efforts. She oversees 140,000 military and civilian employees, and more than 3.5 million beneficiaries, globally. Yes, We Can!.

Who you are does make a difference

It was amazing how the contribution of an individual can make a big difference in matters of a nation, or an area where they have influence. Ms. Inhensiko, an enrolled midwife working in a rural, hard to reach health centre in Uganda, where she was the only health worker at the facility handling both clinical and administrative work for the past three years.

Despite being a midwife and having successfully established reproductive health services at the

health centre, she handled all other medical services at the facility (immunization and treating common cases like Malaria) and offered outreach services in the community, where she was assisted by community volunteers.

Since working in the health centre, immunization coverage in the area was reported to have improved from 60% to 90%; the number of mothers attending antenatal care and/or delivering babies by a trained health worker had improved significantly in the villages served. Her community outreach services, which were conducted every Friday, involved health education have considerably increased community awareness on a number of health issues. (*Damali Inhensiko, Midwife, Inhula Health Centre II, Luuka District Uganda was the winner of* 2016 International Health Workforce Awards *Community Health Care Category*). More available: http://www.who.int/entity/workforcealliance/media/news/2016/who_hw_awards2016/en/index.html

Some more on nurses who have made it:
http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Federal/Nurses-in-Congress

The following interview from the local setting perhaps might address some of these stereotypes. In an end of year interview [69] Newsmakers 2014, the then Cabinet Secretary (CS) Ministry of Health Dr. James Macharia said the following:

…his' was the most devolved ministry. About his appointment being a non-medic, he said that the President made it clear to all and sundry that he was not looking for a medical doctor but looking up to someone who could sort out the management issues within the ministry, someone who can achieve results. The CS said he was enthusiastic about his assignment.

He had settled in the job and people were no longer concerned that he is not a doctor; "now some people think I am a doctor" he quipped. His vision for the year 2015 was to work hard to finish the flagship projects: Free maternity services and installing IT system in all public hospitals and health centres. He saw his legacy would be one who left a-happy-healthy-medical sector.

Who you are does make a difference; this is a true saying when you consider the following: "There are many people doing great things in the world. They are great, and I want to be a great kid too." These were the last words of 11-year-old Liang before his death. The young boy from China had faced much pain and suffering in his last two years had donated his organs to give life to others after his death. Even doctors bowed in reverence to his body.

17.4 Dissatisfaction among Nurses in Kenya

According to Syallow (2010), the result showed that there was a lot of dissatisfaction among nurses in all the five categories of hospitals selected in the study of Rift Valley Province of Kenya. The study highlighted schemes of service and terms of services. It recommended that (nurse) managers when designing jobs should not focus on content alone but on flexibility of working hours. Since rigid and inflexible working hours caused a lot of stress in nursing.

Finances for non-financial nursing education

The changes that I have seen over the last 10 years in nursing focus heavily on economics. As a bedside nurse in the early 2000s, it was rare for me to hear about cost containment, reimbursement, insurance issues, bottoms lines, etc... I feel like every initiative that I now have to present to my staff is rooted in finances. From patient satisfaction to quality and safety initiatives, everything seems to have a reimbursement tag attached to it. Nurses now understand the cost of supplies, how much waste management and health insurance costs the organization, and even whether a patient can pay for their stay or not. In today's hospital setting, I feel like the focus has shifted, and the financial well-being of the hospital has become the "why" in why we do things.

I don't think that we have taken the focus off of patient care; we have simply tied finances to it. The concepts that I have come to learn through my work over time (healthcare policy, insurance, legal issues, etc...) are all things that I wish I had known from class. I wish there was more to the undergrad programs regarding many of these topics. There isn't room to tech nurses everything in health care unless we stop teaching other subjects, but there is no question about what to add to nursing education. [Shared from a US perspective]

The dissatisfaction of the nurse definitely affected the quality of services that ought to be delivered. Maina and Karani (2004) had studied challenges encountered by middle-level nurse managers in ensuring quality nursing care in Kenyatta National Hospital and documented similar findings

According to International Center for Human Resource in Nursing report 2010, Kenya had a great shortage of nurses; whereby the ratio was one (1) nurse to1345 population compared to the ideal standard ratio of 1 nurse to 250 population with barely over a thousand nursing degree holders then in the market (International Council of Nurses, 2010).

Kenya Union of Nurses (KNUN, 2013) sources put the current number of nurses in the public service at 13,000 and a further 8,000 under the Economic Stimulus Package (ESP), the union further demanded that the country of 42 million Kenyans needs 172,000 more nurses in order to improve the quality of healthcare provision in government health facilities. Vihiga county was among the smallest of the 47 counties with a population (2012) of 608,879, population density of 1500 people per Km^2 40 nurses per 100,000.

A Ugandan physician reported that only 12 of his 100 medical school classmates still live and work in Africa. None of them were in direct practice and none worked in the public sector. Possible reasoning was - a perceived lack of a career path in that– they felt they had no future in public service. [Case study cited courtesy of HRH]

According to Kenya Nursing Workforce Report 2012, nurses provided the bulk of direct patient care at all levels of health services delivery. With a shortage of nurses, especially in rural areas, it would have made a lot of sense if we helped the existing ones to be as productive as possible and to perform up to standard. This becomes especially important; notably having them spend more time on direct patient care. Also, see Chapter 11 for a detailed report about nurse managers.

[69]Citizen News *Newsmakers 2014:* 26th Dec 2014, 1-2 pm.

17.4 Outmigration of Kenyan Nurses

Health workers in developing countries are often overworked, poorly paid, and not provided with the necessary equipment and supplies to do their jobs. Their work performance can also suffer due to a lack of adequate supervision and feedback.

A range of gender-related issues, such as inequitable recruitment, hiring, compensation, promotion, and training opportunities as well as sexual harassment and violence in the workplace, may also affect their job satisfaction, retention, and productivity.

Making matters worse, working conditions are deteriorating as demand to incorporate new and labour-intensive services, such as provision of antiretroviral therapy (ART) to persons living with HIV/AIDS, are added to their duties (human resource for health HRH website).

Imagine that you are working in a governmental or non-governmental organization in a developing country and have observed the following:

-Once trained and experienced, clinical health workers routinely leave their rural posts for better opportunities in the cities or abroad.

-Nurses are often overloaded with work, spending their time performing basic tasks that others could be doing.

-Workers sometimes go without pay raises or other recognition for years at a time.

Complex and interconnected set of issues with no simple solutions were related to the health workforce migration and outmigration. Evidence showed that workers often leave because of low compensation, lack of educational or other opportunities, poor working and living environments, and inadequate social amenities. These poor conditions ***push*** workers away from areas where they are most needed.

Simultaneously, better conditions ***pull*** them toward better work opportunities and a better life, resulting in the migration of health workers, both internally (e.g., rural to urban) and internationally.

Factors that affect retention and accelerate migration included:

- Payment and compensation
- Benefits and social security
- Job and professional satisfaction
- Work setting and conditions

Compounding the situation, those health workers who stay on the job face an increased workload and often intolerable and dangerous conditions with little hope of advancement. These factors may lead them to abandon the strong personal commitment that they had to help the people of their own countries or home areas.

Africa had 24% of the global burden of disease and only 3% of the global health workforce. At 2.3 health workers per 1,000 population, Africa had the world's lowest density of health workers. Kenya is an example of a country, where it sometimes took up to 18 months to fill a single

position (HRH, Global Health Workforce Alliancewww.globalhealthlearning.org).

In 2016, sources from NHS Trust of the UK indicated that 40,000 nurses quit their job that year while Netherlands indicated that there were 200,000 nurse shortages by August 2017. Sources from US Bureau of Statistics by mid-2017 predicted that there would be 100,000 vacant registered nurses jobs by the year 2022.

Maybe (and I am speaking as a Kenyan here), it was about time US states' nursing boards and regulatory bodies relooked into the rather tough NCLEX exams. Whether there was need to retake NCLEX by those who had previously passed and were re-entering the profession.

In mid 2017 Nursing and Midwifery Council of the UK (NMC-UK) indicated that more nurses were leaving the national register than those joining it. Some experts thought that men joining nursing might be the solution to this crisis (nursesarena.com). Experts were also fronting a proposal for apprentice model to deliver more trained nurses. Indeed to jumpstart recruitment, UK's Health Secretary Jeremy Hunt announced opening 14,500 places for apprentices to become RNs by 2019.

By end of September 2017 NMC-UK removed the mandatory requirement for test of English for nurses originating from English speaking countries. The nurses' arena floated a survey on what the proposed NMC-IELTS changes meant for foreign nurses. It would be interesting to follow up on this study.

It was around this time that Abu Dhabi in the Emirates indicted that 2000 nurses were urgently needed. In the US the new USCIS form launched around that same time would ensure a seamless process to obtain work authorization documents and security number simultaneously.

Earlier on in 2008 a web site hosted by *majimbokenya.com* had made these projections; 20,000 nurses were needed in the UK, mostly from Africa…'because they are cheaper'. The pay for a new registered nurse (RN) in the US rates was around $27 per hour [approximate equivalent Kshs 2,700 per hour] while UK £ 22,128 per annum [Kshs 1,637,280 per annum] in 2017.

According to Feldstein (2011; pp320), the long run supply of nurses in the US was determined by those who decide to enter nursing school. But due to lack of capacity and shortage of faculty, only 42% of applicants were admitted. The immigration of foreign-trained nurses and getting a greater number of men enter nursing are the next option (Feldstein, 2011; pp. 212). In the short term, part-time RNs increase their hours of work and trained RNs re-enter the workforce. Unlike Kenya, in the developed countries a good number of nurses comprised of those who had entered into nursing after having worked in other jobs or careers. Some in their middle age or above. For example *The unlikely RN* from a brick maker to RN was reported by CNN.com and ♯BeTheNurse.

In the 2000s older nurses re-entered nursing in the US due to economic recession. The increased demand led to strong financial incentives for foreign trained nurses to immigrate. In the US they had increased opportunities for much higher pay (allowing them to remit funds home *from the diaspora* to assist their families), better working conditions and greater prospects for learning and practice.

A closer look at visa application process to the US in recent times had an item in the checklist *Nurse in a shortage area*. Being a nurse thus gave the applicant an almost express privilege to being granted a US visa, and subsequently a work permit.

The U.S. population is aging at a rapid rate; health care reforms (e.g. ObamaCare) were expected to bring millions of more patients into the system, and there are anticipated shortages in numbers of trained health care professionals to care for these patients. It was for these reasons that Work-Force Planning Model (WPM) tool was developed in 2013 by the American Hospital Association, American Organization of Nurse Executives (AONE) and American Society for Healthcare Human Resources Administration (ASSHRA).

The purpose was to help organizations better define their needs as well as find new ways to improve their recruiting, sourcing, retention, retirement, success planning and onboarding strategies. This is a great tool to check out for leaders in health systems and human resources in health. WPM can be accessed through any of these reputable organizations' websites http://www.aone.org, http://www.aha.org, http://www.asshra.org

The Philippines, former Yugoslavia and of late Ethiopia train nurses for export, this author does not see why Kenya cannot realistically develop a similar policy and stand to benefit from diaspora remittances (Kenyans abroad in 2017 remitted Ksh 1 billion becoming the leading source of foreign exchange). With all the mushrooming colleges and universities offering nursing, it is not possible we can absorb those graduates locally despite the nursing shortage we continue to experience as a country.

Nursing programs apparently were a favourite and easily made it into the charts of the 'new' institutions. Nursing in Kenya must remain committed to her ideals. But until we put money into creating jobs for these people rather than just creating supply we need to be more open in the future to a deliberate export route to solve the oversupply problem.

The "new" institutions were actually middle-level technical establishments that have been converted into universities. Mostly the political class aimed for each county to have 'its own' university. These mostly offered programs in business; education; arts and the humanities.

These were relatively cheap to teach but are not really in demand in the labour market, so the institutions probably were not going to do much in addressing Kenya's 40% graduate (and the general 22%) unemployment rate.

The population of youth in Kenya was expected to increase to 16 million by 2012, with as many as 40,000 youth entering the Kenyan employment market that had only created 150,000 new formal sector jobs in six years (USAID -2009).

Students' performance (academic achievement) played an important role in producing the best quality graduates who will become great leaders and provide manpower for this country. That aside, nurse educators are challenged to produce as many graduates as possible to meet the changing needs of the society both locally and the world at large. We really needed some propensity towards a university education that inculcates the graduates to become entrepreneurs or as a minimum opt for informal employment.

The increasing rate of unemployment in the country and the consequent careful selection of degree programs by prospective students should arouse universities to swing into action. They needed to embark on restructuring, rationalization, and harmonization of their academic departments, faculties, schools, institutes, and centers.

Fresh curriculums that have components of transcultural nursing, EBP, relational communication, human technology interface among other niches could become new selling points. Graduates needed to face in the job market confidently. In today's world, the skill to handle information and communication technology had become a necessity in any job place.

Faculty must maintain standards to graduate those who demonstrate after completion of the required coursework eligibility to terminal program competencies. These included like being able to pass Nursing Council of Kenya licensure examination as well others e.g. National Council Licensure Examination (NCLEX-RN) and Commission on Graduates of Foreign Nursing Schools CGFNS). These regulatory bodies' role needed to meet both the demand and supply of nurses.

Even though we here in Kenya might want to overlook the fact that our programs core need to base on the scarcity of nursing professionals in developed countries sooner or later we might. This drive in responsive to market demands has already been happening elsewhere.

For-profit brokerage agents were executing bonds and preparing our Kenyan nurses on behalf of hospitals abroad and were doing big (and at times exploitative) business. There was need to do much more than just take fees from immigrant nurses. What would be wrong with having our institutions accredited as NCLEX/CGFN centres per excellence? Identify responsive contacts, build excellent facilities and staff to offer more competitive standards required by our country and also the recruiters.

This country's nursing old guards must drop their matriarch tendencies and open up. We cannot continue to bank on the glory of the good name Kenyan nurses built before while 'daring abroad'. The standards of training have since fallen; we are producing more with less and for less, perhaps a reaction to economic recession. The challenges on the ground as well as off the ground are different.

Our graduates might get a harder time getting absorbed into the system. This ought to get us soul searching. We have for a long time been working with an elementary theory based on - who is being processed to outmigration? Or rather waiting for those who are interested to come forward. We need to start asking more quality related questions but more importantly: What calibre of nurses are needed, what are we exporting, what are their credentials in as far as competence and professionalism is concerned?

What shall we be doing with all these nursing graduates whom we cannot gainfully employ? We must stop expecting the new powerhouses and their agents to come fishing for them on their own terms. We need to build new networks for actively exporting nurses to burgeoning lucrative places on the globe based on more relevant policies. There was an obvious gap to fill by making nurses' outmigration a sustainable investment through policy reforms.

For the US, in particular, the population is growing and an increasing percentage of the population is becoming older; the baby boomers cohort (born in the 1950s) began retiring in 2011. The RN workforce was also aging; the average projected age for nurses in 2015 was 44.6 years). Medical advances and technology was increasing demand for hospital nurses (Feldstein, 2011; pp325).

But if anything technology was an enabler, it cannot replace the basic clinical or nursing skills. The incidence and prevalence of chronic illnesses was increasing. The demand for ambulatory outpatient services, home nursing and long-term care all point to increased need for nurses in all settings. Some states e.g. California had instituted minimum mandatory nurse to patient acuity ratios.

The number of Kenyan nurses intending to out-migrate for greener pastures continues to be on the rise mainly due to poor working conditions and pay at home, frozen employment by the government, active recruitment agencies, liberalized passport and expedited visa for professionals in some cases.

The cost of training one degree nurse is approximately Kshs. 1,200,000 per year for four years totalling to Kshs. 4.8million. Most of the degree nurses were trained through government sponsorship using tax payers' money. However, they were hardly accorded the opportunity to use their expertise in improving the quality of life for Kenyans.

Instead, a significant proportion of these nurses are poached by developed nations which have robust health systems that value such highly trained nurses. As such, Kenya remains a production unit for these countries in need of highly trained nurses whereas the Kenyan health care system continues to ail due to lack of the very highly trained nursing professionals.

WHO podcast on 09 July 2010 04:00 PM addressed this topic using strongly worded statements (see Improving health workforce migration below). That was some six years back today, yet in 2013 KNUN alleged that over 3000 nurses had out-migrated in the last two years. It would mean making judicial use of training resources to ensure that ongoing employment exercises always include positions for degree nurses with reasonable terms and also endeavour to retain the same within the public sector. The media was averse with this item sometimes ago[70].

Nurses seeking for verification of certificates from the Nursing Council of Kenya were 3,583 between the year 1999 and 2006. The intended host countries were mainly the USA and Britain. Kenya continues to loose highly trained manpower mainly because they lack incentives to work at home.

Incentives, in this case, can be looked at as the conditions within health care provider's work environment that facilitate, enable, encourage and motivate him/her to stay in their jobs, in their profession and to remain in their home countries. The Government freezing of automatic employment of nurses and cost-cutting measures initiated by health care facilities resulting in reduced staffing levels are some of the changes that have had impact on the nurse administrators.

According to Dr. James Kimani, then Director of Medical Services in the Ministry of Medical services, Kenya, Hospital Reforms Priorities 2010-2015 project that Ksh1.1Billion annually will be for recruitment of additional medical staff including nurses. Kshs 481 Million will be for implementing revised scheme of services for 5,900 staff to improve employee satisfaction and retention. A variety of incentives, both financial and non-financial, can be used to address the issue of retention.

Examples of incentives gleaned from HRHwebsite (Global Health Workforce Alliance) that can be introduced at the service delivery level range from providing extra monetary allowances for rural postings or providing houses, cars, or loans for these items to strengthening facility management practices and reducing on the job discrimination, such as that related to HIV status or gender.

In one study in Kenya, simple, low-cost interventions to improve work climate proved successful in retaining health workers. Over the period of one year, 10 rural facilities participated in a program in which the workers themselves identified the elements needed to improve their work environments.

These included more frequent team meetings, community outreach days, inexpensive renovation of facilities, more equitable staff shifts, the creation of staff lounges, and less littered yards, among other measures. Following the intervention, 90% of staff expressed high satisfaction with their work environments, up from 60% before the intervention (Global Health Workforce Alliance). These issues were discussed in chapter 9.

It is a reality that the developed countries also do face serious nurse shortages. The combination of fewer people going into nursing, the retirement of current nurses is expected to produce a shortfall of more than 1 million nurses in the US by 2020 (which is 4 years away today).

In an article published concerning the US, one participant in a focus group discussion (Araskar *et al.,* 2004) described the unrealistic expectation of assigning responsibility to one nurse for three or more patients receiving chemotherapy, which made it impossible to provide holistic care for patients who were desperately ill and often frightened. For her, this was a major ethical dilemma.

Improving health workforce migration

WHO podcast on 09 July 2010 04:00 PM addressed this topic using strongly worded statements: 'High-income countries are increasingly dependent on doctors and nurses who have been trained abroad. But the migration of health workers weakens the health systems in the countries of origin. WHO's Code of practice on the international recruitment of health personnel aims to achieve a balance between the interests of health workers, source countries, and destination countries'.

From where this author sits, the exodus could be getting worse. The *Future of Nursing* (IOM, 2010) campaign of the US recommended recruitment and retention of a diverse nursing workforce as a major priority.

17.7 Nurses Must Be Given Space to Do Their Work

Allowing nurses to step outside of their traditional roles, and help them to grow. From a social–political lens, nursing has remained invisible and externally controlled, as nurses, we reach for meaningful expressions of our values, too often finding overwhelming constraint and resistance, sometimes within ourselves and sometimes imposed from without (National Nurses Association of Kenya-NNAK Agenda 2015). In spite of the scientific facts and evidence that nursing care and caring are crucial variables that make a positive difference in patients' (and nurses') outcomes of health and well-being.

The administrator's goal is to achieve the tasks of nursing as efficiently (i.e. quickly) and as economically as possible. They may not care about the interpersonal relationship that nurses value while giving care. They seek to control nursing actions, to limit caring time and to require concrete measurable outcomes to justify their actions, while nurses beg for time for caring tasks (e.g. listening to clients concerns) which do not have solid, quantifiable outcomes other than patient satisfaction (Morse *et al.,* 1990).

It was notable that patient satisfaction surveys had shortcomings in that some nurses (*Is America still facing nurse shortages?* Blog http://scrubsmag.com/) asked 'hotel style' questions which often gave poor results especially for bedside nursing care.

When the surveys were viewed in light of chronic staff shortages, being expected to work twice as hard with less (pay, utilities etc.) with sicker, sometimes older and heavier patients. The outcomes of the surveys was affected in some way by nurses feeling that they were being under-appreciated by administration and patients'/ families who were often sue happy. Often neither of these parameters considered that the nurses were short staffed.

It has also been shown elsewhere that good patient satisfaction scores may not be found in the same institution with good patient management outcomes, infact in some instances, it may be the opposite as was documented by Robbins (2015) who authored *The problem with satisfied patients.*

[70] Amoni, P.K. 2006: *Exodus of Nurses*, Kenya Times, 9th November 2006, Kenya Times Media- Nairobi.

Being empowered might mean: Capitalizing on the new constitutional dispensation and devolvement of health care to the counties; nurses among other health care workers at all levels needed to become involved in lobbying, coalition building, and relationships with elected representatives.

Client power according to HSA, 2010 report by Luoma *et al.,* (2010) referred to the ability of citizens, citizen groups, and watchdog organizations to monitor and oversee the actions of health providers, ensuring that health services are made available, maintain high quality, and follow accepted norms.

According to Melynk and Fineout-Overholt (2011) being empowered means investing in lifelong skills: asking focused questions and learning to judiciously search the information rich environment efficiently. That is; formulating a searchable, answerable patient-specific question(s), incorporating good information seeking habits into a daily routine mainly through becoming friendly with and proficient at utilizing information technology and internet for what is relevant. Increased involvement must begin at an individual level (e.g., joining a professional organization/union).

Utilizing some aspects Quality Health Care Organizing Framework for Resource-Constrained Health Care Settings in Kenya (QHCOFR-LS) the following is what can be deduced: The devolved health care system, the commissioning of a new national hospital insurance service, free maternity care, increased funding from exchequer all show that this is a time of great opportunity in health care in Kenya for the nursing fraternity. There are many windows of opportunity in this transition period, and Kenyan nurses can leverage these opportunities to institutionalize a culture of quality nursing care and offer leadership on aspects of improvement in things that will be set.

Taking a quick reminder on the nurse manager's report in Chapter 11, when the participants were requested to describe their roles as nurse managers they felt that just like the giraffe was an indomitable figure in any health care setting. He/she bore the image of the hospital, going to great lengths/heights to ensure the smooth running of the institution amidst daunting challenges of a changing work environment.

The public image of nurse professionalism is important. Attributes of a professional nurse, such as caring, attentive, empathetic, efficient, knowledgeable, competent, and approachable, or lack thereof, can contribute positively or negatively to the patient experience. He/she must have a strong vision for nursing, its role in maximizing the patient centred experience and in meeting the organization's goals.

Uncertainty is a fact of life in many a local setting such that some of the tasks the nurse manager did involve making 'backstage disorganization look excellent onstage' (See **The Dignitary** in Chapter 6). For example, when the rest of hospital management is gone off (After 5 PM, weekends, public holidays and all nights), the whole institution is in the Nurse Covering's hands and he/she knows all is not well.

He/she must struggle to remain on top of things even if there were no ready answers to the issue at hand. There seemed to be an apparent disharmony between the supporting structures available for him/her most of the time as well as the system she supports (see **Night Coverage** in Chapter 6).

According to Dr. Bruce Agins of HEALTHQUAL International, delivery of quality health care was a complex process with a lot of moving parts. There had to be someone who had ownership over the management of the work, someone who would make things happen on a daily basis. In Bruce's work, they had tried to find early adopters to buy in, start work, and get results to motivate others to join in (Technical Report, 2013).

From the foregoing of this book this far it would not be imperious to state that nursing offers such a person. But things have to change. It cannot be business as usual. We cannot keep thinking the same way and expect different results. It is stopping such excuse clauses like … *but you know as usual*.

Nurses should take up the relentless quest to advocate for evidence-based practice improvements by engaging in frequent assessment, evaluation, and questioning of current methods of care. It is not ever going to get any easier. *The Prince*, Machiavelli astutely noted some 500 years ago that there was "nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle than to initiate a new order of things".

In healthcare, we have one guarantee and that is, things will change. In order to get whatever it is we want for our health care system, all we have to do is to stop performing the actions that don't bring about the desired result and start performing the actions that do.

Learning how not to is very critical to learning how to. We cannot continue to do things 'the same good old bad old days' way (slavish, routine, ritual, rote, straight jacket of behaviour) and expect to get better results every time.

Prof Mutahi Ngunyi (of The Fort Hall School of Government), a political analyst who I regularly follow on social media said this in an interview:

'*if a banana tree gives you bananas today, gives you bananas tomorrow, gives you bananas the day after, why should you expect the banana tree to give you pineapples on the 4th day or oranges on the 5th day? Essentially you should only expect bananas, the results will be the same one way or the other.*

We know several ways that don't work or don't work well, 'Don't fall in love with your approach – improving care is the key'. The direction is more important than location, so if we do intend not

to change direction, we may end up where we are heading because change continues regardless of our responses.

I was surprised when a student colleague from the US made the following comment about resource constrained settings and as to whether she thought we use EBP:

"I think you definitely could be practicing in a way that is evidenced based without knowing it. But evidence changes all the time and to keep up with the latest evidence, it is important to have that culture and desire to change the status quo. That way you can make sure that your changes are all in the right direction"

There is so much opportunity for change in the health care system. Ralph Waldo Emerson once said, *Do not go where the path leads, go instead where there is no path and leave a trail'* RW Emerson. It seems likely that in resource-constrained settings some are fond following any straight line in the hope that nothing gets their way. It's that serious so that we do not become the very people we are trying to run away from.

A realistic way of achieving better health results: conduct careful analysis to identify evidence- based opportunities for more efficient delivery of health care; whether prevention or treatment and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions (Cohen *et al.,* 2008).

But then according to Kurt Lewin …we must first understand why things have been done a certain way in the past and involve those doers in the solution. The new way needs to satisfy or meet the historical elements of the group's previous behaviour. I see this as a huge part of change buy in (Kaminski, 2000).

As much as we need to introduce new products and services it is important to review the current situation to identify non-value adding services. Some low-value services exist only to follow rigid protocols or justify billing.

No matter how long certain practices have been used, let us be willing to examine others. According to Porter O'Grady & Malloch (2015) in their masterpiece writing *Quantum Leadership*, if an organization provides 1000 services and only 25 make a difference, then the other 975 services must be considered for elimination.

Dialogue was needed to sort out which ones they are per institution or as a nationwide policy first by utilizing strategies such as *mapping resource utilization*. Individual care providers need to feel free get the word out; they need to be empowered to become agents of cost reduction whenever opportunities arise.

Many patients and their health care providers believed that despite limited evidence to support the use of certain healthcare services and products, their individual circumstances may be different, and therefore they may be more likely to benefit. But we need to choose wisely.

We need to bridge the gaps in assuring quality of care we provide. Michael Porter (2012) presented on 'Value Based Health Care' said that significant improvement in value will require fundamental restructuring of health care delivery, not incremental improvements. Noting that today's, 21st-century health care was often delivered to low income countries with 19th-century organization structures and management practices among others.

A nurse observed 'its like being in a hostage situation!' Once you are into these things, it tends to distance you from the patients, but we are helpless without it ... Patients also tend to regard technology as more superior than traditional clinical and nursing care. After all, a wise saying goes that, "there is nothing as inefficient as very efficiently doing things that should not be done at all".

Just like every other healthcare provider, in order to perform at their best nurses require recognition and support. The *Magnate* and *Planetree* accreditation in the US offers some of the best prototypes of what nurses are capable of. Magnet hospitals encourage greater nursing authority. Magnet hospitals are model patient care facilities typically employing a higher proportion of degree prepared nurses (59% BSN compared to 34% BSN in non-Magnet hospitals).

The magnet hospital standards is a program by the American Nurses Credentialing Center (ANCC) recognizing healthcare organizations that demonstrate nursing excellence (Houser and Oman, 2011;p14, 47,249, 251). Magnet recognition represents excellent patient care and clinical outcomes, a supportive and innovative workplace, and development dissemination and enculturation of EBP.

Therefore magnate hospitals must create an environment that uses evidence to preserve the development of nursing knowledge. It lays a lot of emphasis on transformational leadership, EBP, innovation, evolving technology, and evaluation of outcomes.

The foundation for the magnet nursing services program is the scope and standard for nurse administrators:

- It provides a framework to recognize excellence in nursing services management, philosophy, and practice
- Adherence to standards for improving the quality of care
- Leadership of the chief nurse executive and competence of nursing staff
- Attention to the cultural and ethnic diversity of patients, their significant others, and the care providers in the health care system

Although Magnate primarily focuses on nursing practice, it is important that leaders engage all disciplines in sustaining Magnate designation. This is valuable for achieving desired clinical outcomes for patients (Houser and Oman, 2011; p14, 47,249, 251).

17.8 Carelee: The carer of the carer

Nurses enter the field of nursing with the intent to help others and provide empathetic care for patients with diverse health needs. They provide essential psychological and emotional support to patients because they are the ones who spend the most time with them.

Nurses are in the best position to judge minute-to-minute changes in a patient's medical condition. Staffing shortages and falling within the essential job category forces many of them to work double shifts, nights, holidays and weekends. Routinely they were being asked to take in more patients than they could safely handle, a monumental task, given the kind of monitoring and medication needed by each or majority of patients.

Aging nurses, nurses suffering from chronic diseases, worsening shortages of staff all affected nursing workforce productivity. This loss of productivity substantially affected the availability and quality of health care.

Nurses have an important health advantage over the general population such as: being health literate; being educated; being employed; health seeking behaviour, access to personal health care and medical insurance; possessing skills and capacities for self checks e.g. self-breast examination, blood sugar monitoring, blood pressure measurements among others.

Being a nurse means that in many ways you are a role model for health and wellness (do-as-I-say do-as-I-do approach). But just like everyone else, they wish they had a support system guiding them. While this is true self-care can be difficult in today's pressure-packed workplace. It is challenging to focus on your own self-care.

A healthy nurse is certainly a healthy nation, but that statement usually does not get as far as it should. In 2017 the American Nurses Association (ANA) theme was focusing on *2017-The Year*

of the Healthy Nurse working towards "a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing."

ANA through Wiley publishers dedicated collections towards the healthy nurse campaign. These included cancer awareness, work-life balance, sleep-rest issues, combating stress, fitness, women's health, occupational health risks, best in books etc. The Journal of Advanced Nursing (JAN) run *Nurses' Health Virtual Issues.* These resources would be accessible freely between June and November 2017.

In class, nurses learn altruism, to be compassionate and provide care for patients unselfishly. Nurses oftentimes are overwhelmed by the needs of patients. They also interact with this fast-paced world; have families and financial concerns just like anyone else. They often experience a conflict between the moral imperatives of their jobs and the practicalities of their lives.

There has been an increasing awareness of the need to develop ways to "care for our carers". Firstly, it's an organizational responsibility to care for staff, secondly, an obligation amongst peers to support colleagues (peer-assist, peer-challenge), and thirdly, a personal responsibility to care for oneself (Huggard & Huggard, 2008).

'Think of it this way: if you are providing care to patients all day, then going home and taking care of family, only to turn around and come back into work to take care of more patients, you are going to start resenting the patients. You are going to start feeling drained by the people you are trying to help. You are going to feel irritable, tired, sad, angry and frustrated.' - Nursestogether on Tue, Jun 18, 2013

Peer-assist cuts through formal layers, with a motto 'it was not acceptable to refuse a request for help from a colleague nurse' although it acknowledges there are those who have either more expertize or willingness to help. Cognizant of the fact that no two people or issues are exactly the same. In *peer-challenge* peers not only review each other's goals and plans but also best performers are made in charge for improving the performance of worse off performers.

Peer-assist and peer-challenge were described in Bartlett and Ghoshal, (2002), lessons drawn from the British Petroleum (BP). This kind of expands the carelee concept to modified forms of peer-assist, peer-groups, peer-challenge, carelee proper and lastly *self* as a carer of self.

Each would supplement the other's efforts. These require creating processes and a supportive culture to link and leverage the will, forthrightness and expertize of individuals and embed it within the organization to give it a competitive advantage in the health care industry.

Caring in nursing is grounded in the basic empathic relationship between the nurse and the patient; as was explained by Jean Watson (2010). This theory of human caring advocates for relationship-based nursing (RBN). At the core of RBN is empathy and the communication of this empathy to the patient and the family.

It defines empathy as the ability to understand a patient's feelings, understand the situation from patient's perspective, and communicate this understanding to the patient. Over time, working in continuously emotionally charged situations with the suffering, this empathy can become overtaxed and exhausted, but who's caring for the nurse?

Self-awareness is core to stress management. A lot has been written on self-help, do-it-yourself (DIY) prevention and resilience strategies. The principle is that nurses need to take care of

themselves first in order to provide quality patient care. Structures for caring for the carer continue to challenge even health systems of developed countries notwithstanding resource constrained settings.

Some other aspect that the compleat nurse needs to realize in this self-help DIY is to learn to make the first move if and when they need help. *Don't ask "if" the carelee can help, tell them "how."* That's all it is! Don't ask them to figure out how your job is adversely affecting you; they probably understand your situation less than you. Instead, tell them "how." This way you might want to make someone want to truly listen to you and hear about you.

Might be this is someone you admire, an inspiration - someone who could motivate you to tackle a challenge in your career path. Finding, engaging and committing the right resources (including a carelee) to support you is a big discovery. Stop waiting for something to happen but take charge of your career, the odds may ever be in your favour.

In the absence of resources available in the workplace, then personal responsibility might be a fair attempt to address this matter. Non-availability to the nonexistence of such services and the absence of sufficient personnel to provide those services is a characteristic of resource-constrained settings.

The American Nurses Association (ANA) has such forums as *Navigate Nursing*. In one of its clarion calls run something like this *how many of us really can define what a healthy nurse looks like, know the status of our own health, and most importantly, how to improve our wellness? Join the movement, healthy nurse healthy nation!* On a different note, Kenyans might relate with sending to a short code the words: *simama usikike* Swahili for 'stand up and be heard' or *sema usikike* - speak and be heard.

ANA defines a healthy nurse as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. A healthy nurse lives life to the fullest capacity, across the wellness/illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities, and work environments, and ultimately for their patients.

A regular Health Risk Appraisal helps nurses care for themselves by identifying certain risks and providing resources to assist with better health habits.

The nurse's relationship with self is a core concept in managing compassion fatigue. The personal relationship defines how you see yourself as a complete person (Durham& Durham, 2005).

It is essential to understand how you are wired and how you relate with or how this influences your outward expression. Even a relationship with self is not stagnant, it is ever changing. One needs to understand the dynamics. Nurses need to be assertive, to express personal needs and values, and to view work-life balance as an achievable outcome (Koloroutis, 2007).

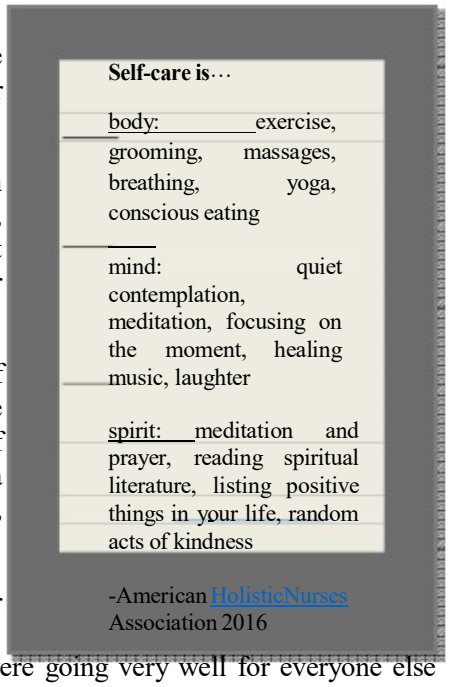
According to Dorothea Orem who came up with Self-care Theory described self-care as comprising those activities performed independently by an individual to promote and maintain personal well-being throughout life.

The assumption being that the carer in resource-constrained setting will be equipped with this knowhow. This calls for engaging in practices of self-investigation, diagnosis, or treatment on the part of the carer themselves which may not always be possible without help.

Fortunately or unfortunately this leads to self-reliance even where outside help would have been indicated. So there is need to teach them to note the opportunity to seek help.

That is why it is vital to have a mentor (or at the minimum a surrogate) who can give you insight into the areas you do not have experience or which you need improvement. This it needs not be the same person all the time and in all areas (Durham and Durham, 2005; pg. 17).

To learn about attitude choose one who has a good attitude and so on. The type of nurse you want to work with. For example, to gain skills when dealing with your emotions choose someone who believes in you and your success, and could help you see where you are going. One who will celebrate your success and not be jittery about it.



Interestingly, Durham (2005) stated that this was often the easiest person to find! Let's take up this challenge, and ask if it was that easy why do most of us fail to - just tap? Why was this information not available, friendlier and easy to use by nurses?

Inherent in the caring profession will be a mixture of reactions: One nurse shared this 'one minute you are celebrating with a family who has gotten healed, in splits of seconds you are grieving with another after losing a loved one. You are the same person, you feel unprepared, as in, it seems no one taught you these things in school'.

It is times like that you need someone to resound your thoughts, your frustrations and all. This was especially critical when one started getting the feeling that things were going very well for everyone else except themselves.

It had been shown that caring for others has often times led to compassion fatigue, burnout and other forms of psychosomatic ailments. It could be described as "Compassion Fatigue: Nothing Left to Give?" (July 2010; letters to the editor. *Nursing Management*).

Once depletion has occurred, too bad - the nurse is personally experiencing the pain of their patients and families in the process of providing empathic support. Burnout onset is more progressive and may cause indifference, disengagement, and withdrawal from patients and the work environment.

Burnout could precipitate compassion fatigue. Compassion fatigue, on the other hand, can be more acute in onset and may precipitate over involvement in patient care. The affected carer gives themselves fully to their patients, finding it difficult to maintain a healthy balance of empathy and objectivity manifesting itself as physical, emotional and spiritual exhaustion (Anewalt, 2009). '…nobody needs a smile so much as those who have none left to give!' remarked an advert *The Value of a Smile at Christmas* in recognition of the pressures its sales clerks were under during the Christmas rush. It added, '… and if in the last-minute rush of

Christmas buying some of our salespeople should be too tired to give you a smile, may we ask you to leave one of yours?'

Compassion fatigue affects not only the nurse in terms of job satisfaction, emotional and physical health but also the workplace environment by decreasing productivity and increasing turnover (Lombardo & Eyre, 2011). One nurse lamented that 'no matter how much or how well they sleep, they still awaken exhausted'.

Burnout and compassion fatigue were being cited as some of the reasons why there was a need to address nurses' retention. It affects both new and old nurses, no one is immune. One nurse leader asked 'how do we retain seasoned nurses who have the experience to give good-quality patient care, those nurses who pride themselves as professional nurses? What about recruiting and retaining the nursing workforce for the future generation?'

Music to sing by

Since time immemorial music has been found to be relaxing to the soul, as such it was therapeutic. *Tazama Africa* is a musical band that had made it their business on voluntary basis to check on patients at Mater Hospital, Nairobi. They did it daily by giving them hope through music. They sang and played their instruments tirelessly, consoling the patients, singing away their waiting time and pain. In the outpatient department this contributed to perceived short waiting time. As evidenced by patients and occasionally nurses tapping their feet and nodding the head to the rhythm. The efforts by these unsung heroes ought to be replicated elsewhere.

Some of the nurses going through compassion fatigue were not even in the best shape to perform. Present-eeism is most commonly conceptualized as attending work despite illness. This contrasts with sickness absence, which involves staying home when ill.

Caring professions appeared to experience a greater prevalence of presenteeism. The consequences of presenteeism were not limited to productivity loss; the behaviour was linked with negative short and long term health problems (Fiorini *et al.,* 2016). In this study, they elicited four factors that predicted nurses' choices between presenteeism, absenteeism, and the consequence of these choices. These included: illness perceptions; work attitudes; organizational factors; and personal factors.

On the other hand, some carried work home, some excess of it. Nowadays keeping in touch with workplace through technology is possible. Telecommuting is a work arrangement that allows employees to work in their homes full time, maintaining their connection to the office through phone, fax, and computer.

Code Compassion on the other hand was studied among nurses in South Western part of the US (Lesley *et al.,* 2017). A unit could call upon the mobile Code Compassion cart containing refreshments, relaxation tips, and awareness messages about compassion fatigue, DVDs with do-it-yourself messages, asking nurses to pause, be mindful, reflect and, address potential burnout.

Whenever that distress signal was received, acknowledging the call, triaging was done. The code was activated together with chaplaincy if need be. Actions included: debriefing and, dialogue among others. Working with nurse leadership issues of time frame, follow-up on nurse's emotional wellbeing, keeping a log on the frequency and type of event and ongoing rounding for continuous awareness.

Awareness of recognizing potentially high burnout situations was highlighted in these institutions: multiple patients' deaths; traumatic/stressful events; prolonged/extreme staff shortages; highly acute cases etc. (Resources available http://dailynurse.com/).

According to American Association of Critical Care Nurses' Standards for Establishing a Healthy Work Environment, there were components that needed to be present to mitigate compassion fatigue. These included: True collaboration; effective decision making; appropriate staffing; skilled communication; meaningful recognition, and authentic leadership. Increased managerial support and feeling of being meaningful recognition experienced a lower compassion fatigue a high compassion satisfaction.

In the study area for Code Compassion they established The DAISY Award, a peer award to nurses who demonstrated lower compassion fatigue with positive attitudes, appreciation of significant moments and, excellence in patient care (Lesley *et al.,* 2017).

This section introduces the *carelee* - a carer of the carer. Carelee is a new concept that stands for *carer of the carer* in this case the nurse taking care of another nurse or nurses, a role that can be assumed by one who is approved by experience, reflective enough to feel and comprehend the constant changes across time through inquiry, caring, and practice of this walk that we call nursing.

One who will also help you identify among others: personal health, safety, and wellness risks, as well as create a plan to mitigate or eliminate them. Therefore carelee was not some form of neurogism – trying to create a new word. Nursing theorists had a history of creating such concepts, a tendency unique for each profession.

Caring is at the heart of effective leadership, therefore, carelee is a broader concept going beyond compassion fatigue and burnout to mentoring on the beauty of caring and what might be causing disillusion among nurses especially in Kenya (and perhaps other resource-limited settings). Some experienced nurses explained 'the work of nursing was like an iceberg, what you see on the surface is nothing compared to what was hidden below the water or behind the scenes'.

Attempting to delineate each context with a kind of mix and match approach. This author believes this approach would work for readers in these settings, who might not have had that luxury of a formal system that acknowledges that carers need care in the first place.

Much as caring for the caregiver as a concept is not new, carelee is - a paradigm of looking at nursing care. According to Sharma (1997), a paradigm is simply a way of looking at a circumstance or at life in general. Some people see the glass of life as half full or half empty. The optimists see it as half full.

They interpret the same circumstance differently because they have adopted a different paradigm. A paradigm is basically the lens through which you see the events of your life, both external and internal.

For example, a carelee is not necessarily the caressing – tender - loving care type but one who knows you, your values, your personality, your passion, and your purpose. Such that in any case even if they happened to be outside your situation, they are never that far, they would be willing to become an accountability partner, bring to your attention any inconsistencies. The relationship is reciprocal too if both of you are to get the best out of it.

For example do not respond negatively or defensively when the carelee brings something up. Be approachable, be open, and be forever thankful for their investment and support. 'Please do not underestimate the power of trustful outside eyes and a firm, but reassuring, voice' (Brittney & Katti 2017) while referring to the role of an accountability partner.

But it could be one of those 'supportive nurse managers who bend over backwards to accommodate our personal lives and who recognize us for all we do'. Nothing wrong with that. It is one who will tell you the truth, tell it as it was, make you come to terms with the complexity of care, build you up to face tomorrow and the realities of care with courage.

This was unlike the conventional role of the role of mentor, preceptor, and counsellor. Perhaps a controversial one for that matter. The mentee who wants to be like their mentor the carer is herself and grows their own brand more or less independent of the carelee.



Pic: Carelee, modeling and role-modeling (Courtesy of clip developer)

Caring is the reverse of possessing, manipulating, or dominating. In any actual instance of caring, there must be someone or something specific that is cared for. Caring cannot occur in a nonrepresentational or in an abstract manner, nor can it occur by sheer habit.

An essential ingredient of caring is communication: a dynamic, developmental process of transmitting perceptions, thoughts, and ideas in verbal, non-verbal, and written (direct or indirect) interactions. Within an intentional caring process, messages are effectively conveyed by persons or through technology.

Other essential ingredients of the caring process are knowledge, self-awareness, patience, honesty, trust, humility, hope, and courage. The nursing interventions need to have cultural and ethnic relevance for the client and are carried out within the ethical and legal domains of practice. To promote a safe, effective quality care environment

The carelee will walk with you up the flights as a nudging, prodding reminder that there is a flight of stairs up, a landing ahead and that the way down will be easier perhaps, more dangerous at times. Note we are using:of the carer notfor the carer in that the responsibility of care would not be essentially be transferred to the carelee. This is someone whose judgment you trust; someone who will be honest with you and not just tell you what you want to hear.

Hopefully, if we had more carelees we would reduce the drifting of our nurses, give them a reason to believe in themselves and perhaps retain many more in the profession of caring. One can allocate him or herself the role of *carelee* of the carer. Nursing nurses promote stress resilience (Figley & Abendroth, 2011) in *Caring for the Caregiver*.

It's essential for the carelee to develop a one-on-one relationship with the individual nurse in order to provide support and guidance. Those who may be in need of referral counselling should be spotted early. Seeking out a mentor, supervisor, experienced nurse, or a charge nurse who understands the norms and expectations of one's unit may assist in identifying strategies that would help cope with the current work situation (Lombardo & Eyre, 2011).

Due to rapid changes in health care sector in general, nursing had become not only more competent-based but more evidence- based-knowledge intensive. Quality was the BUZZ word; it had become a basic in the globalized world.



Pic: Carelee one-on-one relationship with the individual nurse

It would be good to appreciate that in this world, whatever course in life you decide to take some people somewhere will tell you, you are wrong, how wrong, what is wrong. Infact there will be one or two who will tell you what is wrong with you.

Sometimes you need some pushing in order to realize your potential, one who sees who you are for what you are, who can give that push. One who will say 'this is not the end of the world, give your hand and we are going'. In other words, one who believes in you.

Carelee relationship can start off on an informal basis but ultimately this ought to be recognized, formalized and compensated for effort. 'Using mature or older nurses to mold and guide new graduates in the right direction needs to be the main focus in all hospitals' (Lee & Anstead 2010).

Those with the ability to listen deeply, offer caring and innovative options based on their own experiences. Talking about one's concerns and feelings with an appropriate person can give support and hope to the caregiver and assist with the development of an action plan. Consider the following quote:

An organization's success was determined by having the right teams at the right places. *'Wrong people in the wrong place creates regression, right people in the wrong place create frustration, wrong pleaple in the right place create stagnation, while right people in the right place create progression'.* Dr John Kithaka, Captains of Industry, Profiles of Kenya's Leading CEOs. *The Standard* June 10, 2015.Pp7.

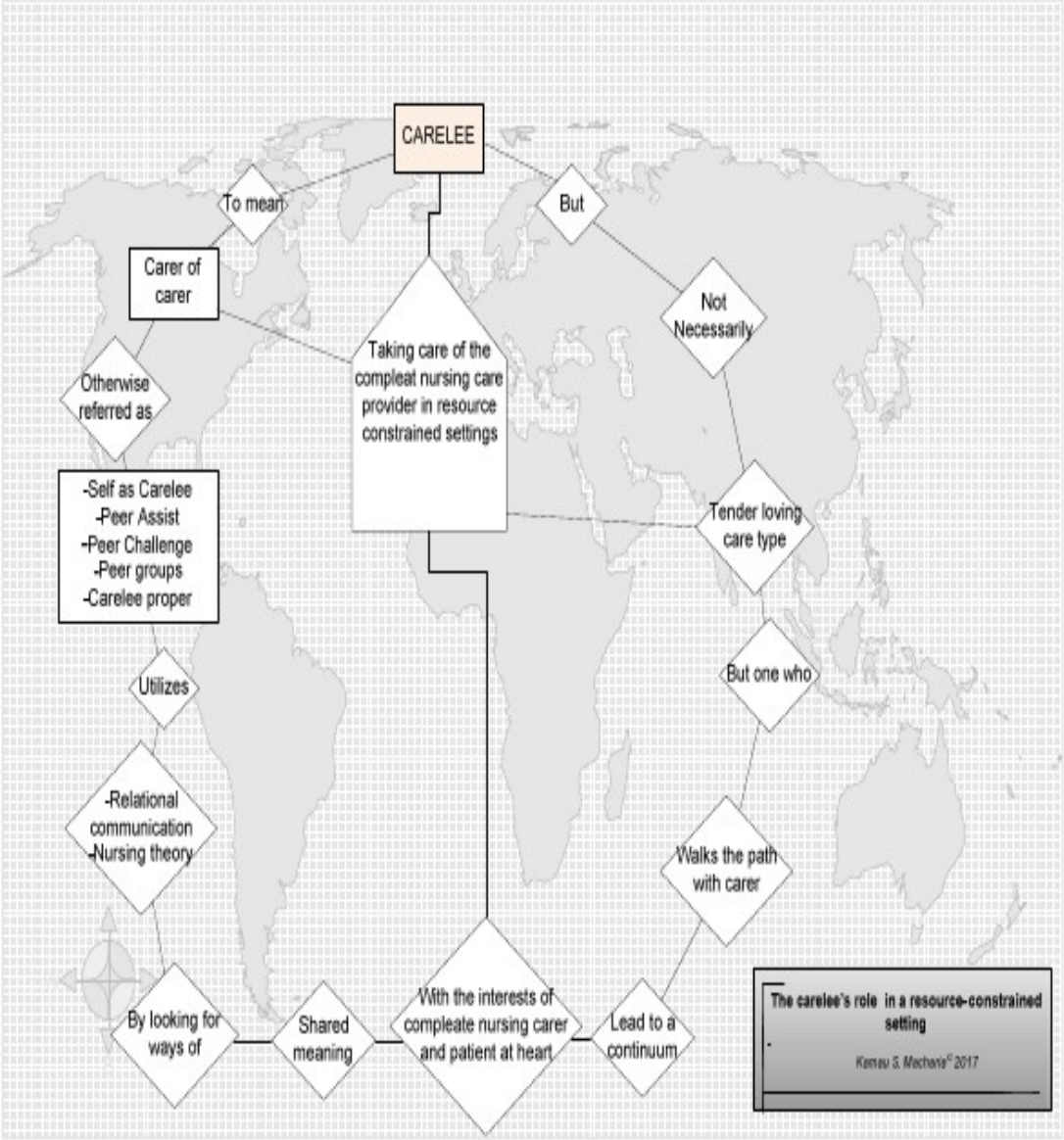


Fig: The carelee's role of taking care of compleat nursing care provider

Also see Carelee on Nurses Wikipedia (user draft)
https://en.wikipedia.org/wiki/User_talk%3ASymomash?oldid=736733792.

Lastly, we could even extend the mentoring to the diaspora; pair our nurses to some program partners on expectations, as global citizens to make them employable. May be create resource centers where they could connect with diaspora. A centre where they could engage in basic life skills, information and opportunities. However since this notion was still developing it will require another forum.

I was not going to tell nurses (of whatever age) how to find work-life balance. His or her values, desires and view of the world might be so much different from mine. Even their idea of balance will look differently from mine. BFigure out what works for you and your life. This is an ever evolving area anyone could share what works for them for the

benefit of others. There are researchers dedicated to this very topic for the rest of their lives.

17.8.1 Moving parts

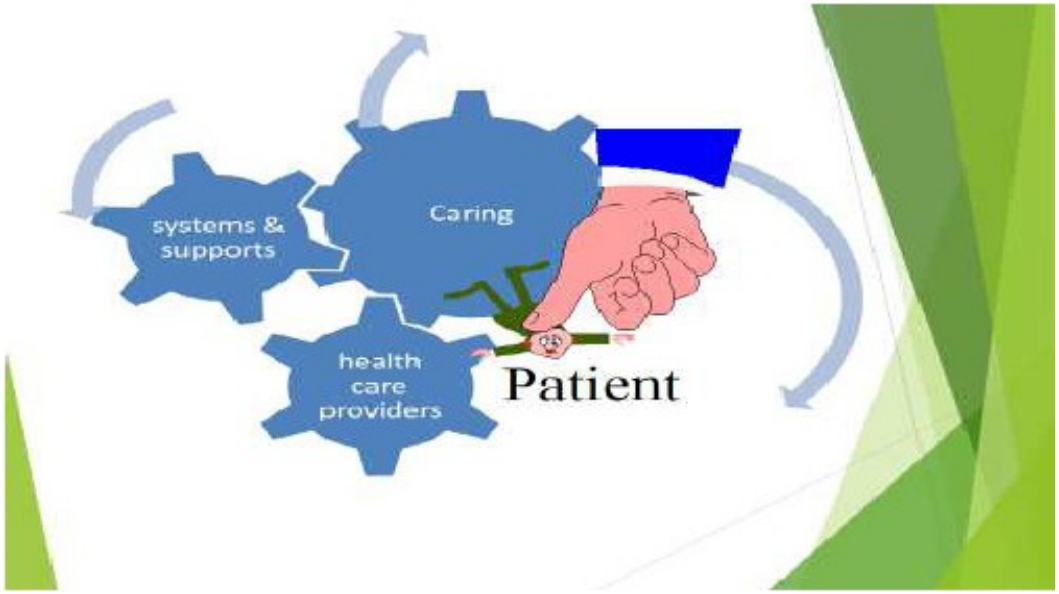


Fig: **The moving parts & cracks of the health system**

There was a cost of lost opportunities, failure etc. when either part tried to extricate itself from the committment to being held mutually accountable. 'Caring is more than a cog wheel - it is a vital fulcrum. Sometimes the carer might be crushed leading to pulling in different directions; the patient might fall through the cracks'. [*Caption developed by Kamau, S. Macharia, 2018*©].

Every moving part in the health system is important. By default others recognize that nursing is more than a cog in the wheel in the system; in that that nurses can provide that vital fulcrum/ convener for the moving parts which in essence was caring. It is not anything nurses had chosen to be, it is by design that caring is the heart of health system and so is nursing. Alongside this let us consider the following sentiments however skewed.

The fulcrum describing this phenomena was borrowed in part from Nigerian poet Dike Chukwumenje who narrated how “Things have fallen apart and the centre cannot hold”. The health system must have faith in the fulcrum; reforms need to be transformative beginning with the nurse.

The nurse-patient/family relationship is the cornerstone of nursing practice and leverages the powerful role relationships play in creating a caring and healing environment. According to the nursing professional practice model (PPM) by American Nurse Association 2010, the six nursing values embedded in the practice and underscoring their work were professionalism, patient and family centred, compassion, teamwork, excellence, and integrity (Winter, 2015).

Holding back this benefit due to them (and by extension the patient) will largely weaken the cog wheels. It is not a liberty that nurses themselves even needed to (but have to) fight for, the rest of the parts need to accord them that due. Trying a no-nonsense supervisor (in Swahili *nyapara* type) on them the way some of the county governments had started going about it would be the last straw that broke the camel's back and emancipate the production of everyone else.

> *Mimi nashangaa maana only nurses among the 20 cadres are on strike…ati wanfunga hos… where the others. Imagine 1/20 stronger than 19/20…* Paraphrased from Swahili English 'Sheng'. Imagine only nurses out of the 20 or so cadres of medical staff were on strike, yet some hospitals were but closed. Where were the others? Do we then take it that
> 1/20 (nurses) was stronger than 19/20 (the rest)? [On 7th August 2017, a subscriber A.M.
>
> posted on Face book wall *Enlightening Nurses*. This was as the national nurses' strike had entered the 65th day].
>
> Someone observed that a good number of the other cadres 'smartly' liked to ride on the others' strike with they themselves threatening to strike, ever postponing it, feigning some united front with the cadre on strike. With some getting CBAs signed without ever needing to go on strike while others were still on strike. The employers using docile group as a bait or may be using them to prove a point. All the while each one of them *prayed, preyed or scaveged* on what the hunter got.

Going back to the concept of moving parts, it was unfortunate that in some resource-constrained settings the moving parts often times appear to have one common agenda: - to crush the fulcrum. Everyone then pulls in a different direction, and the patient might fall through the cracks.

Abraham Lincoln once began a letter saying: "Everybody likes a compliment." Professor William James also said: "The deepest principle in human nature is the craving to be appreciated." Few health care providers realize the effects of even little courtesies in oiling the cogs of the (sometimes) monotonous grind of everyday caring - and, incidentally were the hallmark of functional health care teams.



(Courtesy of clip developer)

But even within nursing the same could be said. It was unfortunate a lot of court processes (between 2014- 2018) instituted by a section of Kenyan nurses against other nurses or nursing bodies had wreaked the very pillars that would have made the fulcrum strong .

These included cases e.g. blocking the implementation of the *Nurses Scheme of Service*, blocking the implementation of the Health Bill 2015 (now Health Act); blocking the appointed Director of Nursing Services from assuming office; blocking KNUN elections from taking place; blocking and degazzetting of elected representatives to the Nursing Council of Kenya from assuming office; blocking the job evaluation by Salaries Review & Remuneration Commission (SRC) etc. Different factions fought each other in public and more fiercely on social media platforms.





Figures:Why do nurses do other people's work? (Courtesy of Nurseslecture room), Question: 'I can't even handle one IV pump, how do you deal with 10 or more IV pump at one time and what *sic*… is wrong with this patient ?'(Courtesy of JustNurses.com)

Whenever the productivity in the health care organizations became less than pleasant from time to time and even on a day to day basis, nurses and by extension patients had borne the blunt of it. Though this might have been caused by new changes: anything from cost cutting to lack of basic necessities for care delivery et cetera, it could more likely be an element of employees' behaviour.

Patterson *et al.,* (2012, p11-14) in their research on organizational productivity and performance documented in the book *Crucial Conversations* concluded that some of the real problems why organizations failed were that the real problems were related to employee behaviour. Not the nonhuman processes, systems, and structures.

There were shocking deficiencies on concepts on human relations and communication in our educational system. They suggested that the solution was in holding one another accountable to the process. In their findings - '… in the best companies, everyone held everyone else accountable regardless of level or position'. Getting people to do that was a necessary skill (tools for crucial conversations).

We need to be cognizant of the fact that "In healthcare, you can't be an 'I' person; you have to be a 'we' person," observed Elizabeth Wykpisz, Chief Nursing Officer at Saint Peter's University Hospital, New Jersey USA (Fiercehealth *ebook,* 2014).

'If we could cultivate good communication skills and employ a 'never ending improvement' KAIZEN strategy you should be able to say like the Toyota that 'the car ahead is always a Toyota' and less like one its long time competitor 'unspoiled by improvement' and almost running itself into oblivion in the 21st century cutthroat competition', remarked one motivational speaker.

Today world over (perhaps with exception of some resource-constrained settings) nurses, in general, had the tenacity to be heard and state their own opinions. In today's world, we are told to open our minds, get into (the) trouble of thinking for ourselves and our mouths to be heard.

The opinionated, well-spoken individuals were becoming the new norm, no more any less the patients we care for. We should tend to find a middle ground on issues but rarely if ever should we solemnly agree on something in its original context. "Going along to get along" brought us to where we used to, wanting to appease everyone except ourselves, and we stagnated there for a long time.

For example, anecdotal evidence showed that nurses' autonomy could be an elusive if not strange phenomenon. From this author's experience, the mention of the word autonomy did not elicit much in terms of achievement or expectation by a section of nurses from one teaching hospital in western Kenya.

17.8.2 Disenchantment among carers

The following section is not a cure to the phenomena called di**ss**atisfaction or disappointment with/about caring and the nursing career. It is not anywhere near to therapy either; it is just a way to get started.

One of the main causes of frustration in nursing arose from inter-professional tensions. Health care had an inherent hierarchal structure with power distances between individuals and that was a cause for a lot of friction (picture the cogwheel again).

For example tensions between nurses and physicians arose because of overlapping roles, nurses' desire for collegiality, and changing role relationships as nurses achieve increased levels of education.

Consider this: the concerned nurses were interdected while the neurosurgeon's admission rights were withdrawn for operating on the wrong patient in the March 2018 KNH case. Investigations and blame game ongoing.

Tell-tale signs of compassion fatigue

Blaming, Chronic lateness,

Depression, Diminished sense of personal accomplishment,

Exhaustion (physical or emotional),

Frequent headaches, Gastrointestinal complaints, Hypertension,

High self-expectations, Hopelessness,

Inability to maintain balance of empathy and objectivity,

Increased irritability,

Abusing - drugs, alcohol or food,

When Venning *et al.,* (2000) did a random control trial comparing nurses and physicians, the research showed that nurse practitioners could do some of what doctors did, usually to the greater satisfaction of patients.

Career counsellors tended to agree - *that there is no best and worst career, degree or diploma programme. Life is all about what you make out of what you have. No degree course guarantees you success or failure in life.* I sought to get a clarification on this general observation.

According to Robert Kahiga, a career advisor based at Centre for Career Development, Kenyatta University described several factors to consider for choosing a course/career:

1. Passion/interest
2. Ability to do the subjects
3. Personality –physical

-social -psychological-
stress levels

4. Opportunities
5. Levels of progression
6. Money
7. Entrepreneurship
8. Networking

Points to Ponder

'It is not who is right but what is right that matters' and "There is no limit to what you can accomplish if you don't care who gets the credit."

Moreover "The patient may not remember your name (or titles after or before it) but they would not forget the care you gave them".

The days of the lone scholar are waning fast, it's about networking, collaborations, making references not necessarily how much one knows.

On the other hand, this author felt that based on the above parameters a nurse ought to be fascinated by the immensity of possibilities available in nursing both locally and globally.

Knowledge actually increases when it is shared, so there is need to distribute value to each member of the team. All individuals in the collaborative team ought to contribute competently since they were all working towards the same goal and deserved the right to define the critical elements of their roles, challenges, and expectations. Even by not hiding critical information including errors.

One approach that had been found to work and is recommended goes like: 'Do Not Say That You Nearly Asked, Ask!' Never be reluctant to ask even the most basic of questions. Questions are the most effective method of eliciting knowledge. This resets and synchronizes collaborative roles of every team member.

Everyone in the team should generally appreciate constructive, timely, and sensitively delivered feedback that could be put into practical use. Gone by were the days when one would be asked: Who are you? Who do you think you are? What can a mere … mere that?

What makes you think that you can? One of the biggest disappointment in the caring profession as summed up by one nurse 'was the politics involved with healthcare and the disrespect of the different levels health care providers …We all could be great together if we respected each other.'

It would be professional elitism for any one professional to over-evaluate their own significance, think for everyone else, expecting them to defer to him or her. Same with expecting others to

twist themselves into shapes to please him or her. In a 'Don't talk to us until we talk to you culture' a cartoonist depicted a laughable 'when we need your opinion we will give it to you'.

> 'We need to dissolve the lie that some people have a right to think of others as theirproperty.
> And we need at last to form a circle that includes us all, in which all of us are seen as equal'
> – Barbara Deming

We needed to encourage others to challenge us, to take their ideas and suggestions seriously, their ability to take initiative, to believe in them in turn as we expect them to believe in us. We should never lose a momentum in the name of egoism.

There is no existence without co-existence. Attacks must be set aside in recognition of the fact that we are all in this together. Focusing on the patient is the common reason why each of us is here in the first place. Each individual needed to confront the ways their own behaviour actually drives this goal or otherwise.

Nevertheless, some of the reasons as to why a section of medical staff preyed on others were what I would call 'unpaid bills' by e.g., the nurses. Meaning that some harassment came because some of the nurse(s) just as could happen with any other health care provider(s) had not done their job properly, lacked training/information needed, lacked interest in what they were doing, did not believe in themselves, lacked in academic upkeep for level of performance required or just incompetence.

Incompetence to this author means lacking sound doctrine why one was doing what they do or are doing. While Porter-O'Grady and Malloch (2015) described that, 'Competence is not simply what people know. Competence is what people do with what they know and how well that makes a difference for others'.

The International Council of Nurses (ICN) had called for competency-based curriculum, defining competencies as characteristics that graduating students should demonstrate which indicate they were prepared to perform and function independently in professional practice. This meant that we must ensure newly qualified nurses were better prepared for the realities of nursing practice. That they had the skills-set that were applicable to the marketplace. That they had what it takes.

The bottom line is you can only give what you have. You cannot convince anyone you can 'pay the bills' when you are bloke, and they can see it. Nursing is not for the faint-hearted, it is for those who will work hard to thrive in the business that nursing is. Run your nursing career like a business/a consultancy though not entirely so but rather with a touch of a labour of love and compassion. Compassion and daily acts of kindness make life far richer (Sharma, 1997).

A touch of labour of love and compassion could mean contributing by giving your time and energy (your two most valuable resources) in a kinder and gentler way) in order to bring meaning to someone's life. It's about judging people by the size of their commitment to others. Unfortunately, this could often lead to inadequate self-care behaviours and increased self-sacrifice in the helper's role.

One needs to be constantly looking for ways to create new energy for self and the workplace. In nursing this might mean being able to rise above monotony, making pleasant routine nursing tasks among other things.

> It was becoming likely that the only new knowledge that some care providers got was from the hints and facts thrown about during the clinical rounds without taking the bother to find out more, confirm the facts. Even a simple fact check online would do for figures thrown around.
>
> Unfortunately, especially in public hospitals for whatever reason, it had become increasingly common for a scheduled clinical ward round to begin, continue or end without a nurse attending (at best a BSN intern or student nurse attends albeit without wishing to have their presence felt). Even the far between Continuous Professional Development (CPDs) staff attended needed to be timely, evidence-based, relevant and applicable to the work environment. There was no shortcut to knowledge, one must find out.
>
> Some of the means some healthcare providers had resorted to like *faceworks* cannot work all the time and in fact can be a disgrace to the profession. Faceworks in relational communication refers to specific messages or behaviours that thwart or minimize the threat/damage such as: avoiding certain topics, changing the subject, or pretending not to notice, in other words, similar to an interesting cartoon found on social media entitled: *the face I make when I am clueless during clinicals*. JM on February 6th, 2015 posted on Kenya National Union of Nurses (KNUN) wall the following:
>
> '…our level of engagement in discussion is too low we cannot speak our minds in the care of the patient. We have reduced ourselves to followers of instructions and not partners in the health care team as it should be ... giving only tentative or unsure feedback as if what they have done is inappropriate'.
>
> After many years this author served in the hospital as a nurse he shares this conclusion. Do not be yoked to people whose aim is to bring you down, or rather do not allow people to put you down. This is *a stone and a hard place* dilemma considering what I am going to say next. Most of the time people don't mean anything bad with their questions.

Don't take questions too personal. Even if the tone and attitude of whoever is asking to seem aggressive. Even if it seems they make you look silly. Stay cool and be polite. Above all be professional. Endeavour to shape the events of your life rather than being shaped by them. 'Remember no one can make you feel inferior without your consent'. –Eleanor Roosevelt.

Do not be too curious about who and why you, may be some bit of what of the issue, but no more. Keep it simple, don't overanalyse or overcomplicate things. Do not be the one to start cat fights, especially in public. William James said: "the essence of genius is knowing what to overlook."

You cannot make those critical patient care decisions when you are angry. You need to ensure that you are free to focus your attention on what matters most to patients. Conserve your energies by not allowing others to spoil your day. Stories have been told of people who walked out of the ward and out of nursing in the heat of the moment.

One did so because of their hospital's rigid policy on intangible things which not the least were the white dress, apron and cape. This is uncalled for and unnecessary. If it is getting out of hand report the incident to someone senior. You can even take leave of absence if need be. Consider the following incident that was shared on Forbes.

"… I am going to quit my job today". "Sensing the hesitation and insecurity in my voice …do not quit. Ask for the time off." I thought she was crazy. "Ask for the time off?" I replied.

I … walked into my boss' office (with no intention of asking for the time off), and blurted out "I need some time off." He replied, "How much time?" and I said, "Six to nine months." My boss sat quietly for a moment then said, "Okay." I was in disbelief. Had this just happened? The moral - it can't hurt to ask

It was during such breaks that some people found in unconventional ways jobs they came to love. Steve Jobs of Apple Macintosh would attest to that. His career path was one about loss, recovery but little to regret about.

Campaign for Action (2015) Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report (IOM) 2010 *The Future of Nursing* report included: nursing should broaden its coalition to include more diverse stakeholders. The Campaign should build on its successes and work with other health professions groups, policy makers, and the community to build common ground around removing scope-of-practice restrictions, increasing interprofessional collaboration, and addressing other issues to improve health care practice in the interest of patients.

Often the care team was quite dysfunctional because of basic cross wiring in the command and control of the team. One Dr.Kevin insinuated that listening to nurses is a key to being a good doctor. I couldn't agree more. Posing this question, 'who knows more about the patient and how they were responding (or not) to your treatment… the doctor or the nurse?' He observed that apart from the military the medical profession was the other caree that involved giving and receiving orders in team communication.

Almost exclusively the doctor ordered other members of the team; obviously, the nurses received the blunt of it. Often times they were curt, dismissive, in a rush did not listen to input from other members of the team or else flat failed to ask!

Dr. Drummond MD posted on April 16th, 2017 'Doctors and nurses need to order less, listen more' in *LeadNurseAfrica* wall on Facebook. He recommended that doctors needed to ask more questions, listen to more, value what they were hearing and act on it. Even listen between the

lines where possible. More important it was good courtesy to want to know how the nurse or the doctor for that matter was doing with a 'how are you doing'.

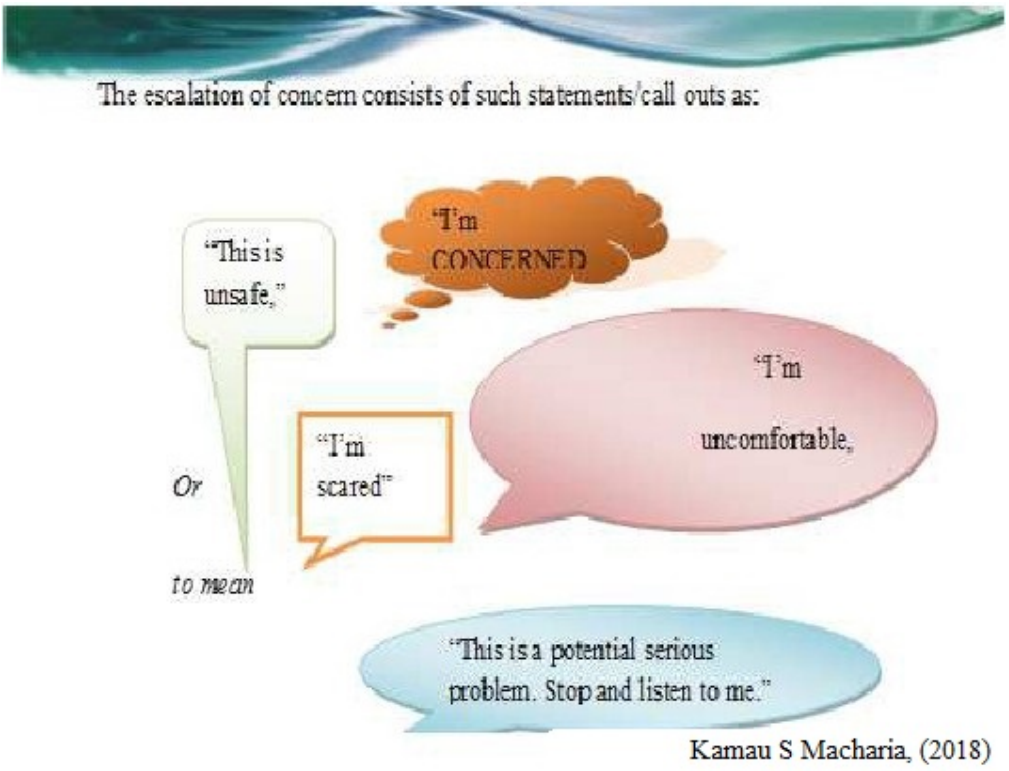
Quoting from Dr. Oscar London MD in *'Kill as few patients as possible*':

'Working with a good nurse is one of the great joys of being a doctor. I cannot understand physicians who adopt an adversarial relationship with nurse. They were depriving themselves of an education in hospital wisdom'.

To ensure quality of health care provision in resource-constrained settings it might become necessary to use a form of assertive language. It was important that when necessary, health care providers politely assert themselves to support patient safety. An effective assertion is pleasant, persistent, timely and clear in offering solutions to presenting problems (Lo, 2015).

There was need to have an environment in which the nurse could raise concerns on behalf of their patients without fear of recrimination, and where such concerns would be properly and thoroughly investigated. In 'The two-challenge rule', a concern is stated at least two times to ensure it has been heard. There is a common nurses' saying - *practice with a questioning attitude.* The saying would reign especially true in such scenarios. Trust your nurse gut if you start to get a bad feeling about an issue.

This is also referred to as **Escalation of Concern** with such statements as seen below:



It would be good to urge each one of us to measure up, detest mediocrity and move to the next level. It is absurd to be entrusted with the care of a patient whose condition you half-understand and whose management appears outlandish without bothering to find out. It is neither witty nor relevant to be a member of such a team.

One cannot be the centre of attack in which everyone aims their heretics unless you choose to be one. I do not mean being challenged, everyone ought to get a dose of it now and then and I believe it is healthy; nuances will always be in every profession. It does no one any good to fret and brood over trivial matters like the comment of a co-worker that sounded like ill-will. Say No to the habit of processing and interpreting negatives. It is not healthy to spend most of your day fretting over past events that you have no power to change.

Do not get to the point where you do not see a way out. If and when you start to view nursing as dull, menial and hard work and see no reward to it or rather the fact that you see it that way means that there is a better way of looking at it. It is unlikely that you are *The First, The Only or Chosen To Be Different*.

You are not necessarily being asked to break records but you could. But then you ask, 'how can you care for others if you cannot even care for yourself? How can you do good if you don't even feel good? It's almost instinctive that nurses take care of others before taking care of themselves. No longer! Ever heard what they say in the airlines? *Put the oxygen mask on yourself before you place it on your child.* Support yourself, help yourself, and take care of yourself, so that you can better serve your patients and clients.

It is not good enough living day in day out with mismatched expectations in work-lifebalance. So much self-help and career advice were geared toward helping people pursue happiness, but there is need to add a voice in the case for nurses. The reason why you joined nursing in the first place might be the place to start. I like the way St Luke's University in Japan; School of Nursing put it concerning those intending to join nursing. They must be:

Someone who is concerned about others and sensitive to their needs; Someone who considers inter-human relations precious; Someone who can share in others' pain and suffering; Someone with scientific curiosity; Someone with a keen interest in global health.

Positivity and self-awareness are at the core of being able to sustain your life in healthcare. These are two of the seemingly easier ideas but it takes self-awareness to remain positive. A lot of guided patience is needed by nurses experiencing role conflict (described as inconsistent job obligations). They need a carelee.

This is because nurses experiencing role ambiguity were reported to be less satisfied with their jobs which in turn negatively influenced their job performance and also lowered their organizational commitment (Wu *et al.,* 2006). Might be this was what Durham (2005) otherwise called, 'the goal is to keep a 'good' job rather than to perform exceptionally'. It is no way to work even if you happened to 'Be Your Own Boss' (BYOB) (See **Point to ponder** below).

For many nurses (at least those I know) in Kenya, this was their first job; it would be good to give it everything you got. Be passionate about what you do and most likely, you will like it. Challenges will not seem like challenges at all, and somehow one can leap a seed of an equivalent benefit from any setback.

One nurse on holiday put it this way:

> 'Will I ever develop the ability to leave my nursing identity behind on vacations? I don't think so. Nursing is what I do and a huge part of whom I am. I don't know about you, but I just can't help myself'.
>
> I discovered that it was far easier to be instantly transported from vacation mode to nurse mode than vice versa. All I could think about was the boy. A patient…er…a passenger

fall? Where was the incident report? Follow-up? Then I thought, "Should I follow the staff's advice, stop being such a nurse, and just enjoy myself?" David Foley (2017).

American Nurse Today;12(4)

In all fairness, you might simply feel or it's actually so that you don't fit well with the profession or the team you are working with. It may or may not seem like a conscious decision you've made or not made but you got to where you are by some of your own decisions. The reality is that every minute you spend doing one thing you are making a conscious choice not to do another.

One nurse commented, 'Nursing is hard work that weeds out many of those who are not happy or fulfilled'. Most veteran nurses confess that the 1st year of nursing was the hardest (nursingguide.ph) but it could vary from one individual to another.



Mural courtesy of the clip developer

Where did the rain start beating you? If such moments are not addressed, it can be dangerous for organization's and your health. It is not good to be too hard on yourself either. Let's face it - not everyone does an outstanding job all the time. Those few times we need someone to tell us the hard truth.

Unfortunately, most bosses point out the bad and assume the good. You need to admit it whenever possible and move on. But it is a choice you have to deliberately make in order to enable the team to move on.

The morale of a team can be infected by (you or someone else) being the intentional "odd person out." If we could rule out that you are not the cause of some of the burn out then we might figure out something else; consider these in yourself. Could it be that you got some of these 8 characteristics below?

Point to ponder

William James said: "I have no doubt whatsoever that most people live, whether physically, intellectually, or morally, in a very restricted circle of their potential being. They make use of a very small portion of their possible consciousness… much like a man who, out of his whole body…, should get into the habit of using and moving only his little finger… We all have reservoirs of life to draw upon, of which we do not dream."

Being resistant to every change. Whenever a new idea is presented, always being the first to say it won't work. You don't have to have a reason. Just oppose it.

Always being negative - about everything. Seeing the glass half-empty. Always. There's nothing good about this place - leader – idea - day - the patients - life. This is not advocating always agreeing with a team and we have covered that in Groupthink.

It's OK to have different opinions, challenge the system - and even the leader. Differing viewpoints help make us all better. The key is to do so in a spirit of cooperation, not a spirit of disruption. You don't have to be the odd person out - even if you're different from everyone else. In fact, don't be.

Always having an excuse. That it's not your fault. It's someone else's fault. Always.

Never having the solution. It's your job to point out problems, not to help solve them. In fact, you don't care to build - you're here to tear down, cut the pillars that support the system, *and*, you intend to do that part of your job well.

Holding opinions/suggestions until after something isn't working well. Making sure everyone knows you were opposed to the idea from the start. You can clearly see how things should have been done. And, you make sure everyone knows how it could have been preempted then but wasn't. Neither does the advancing an aloof attitude commonly referred to as 'Just helping a fellow brewer with an answer… not telling him to do it'.

Talking behind people's back, rather than going to the source - it stirs more drama if you talk about someone rather than to someone. Of course, you talk behind the leader's back too, though you're usually extremely pleasant in their presence.

Refuse to participate in any team social activities. Who needs who, them, right? Why would you want to hang out with people you work with anyway? You might get to know them - and they might get to know you.

Don't buy into the vision. And, actually, this translates into working against the vision. You may even have a vision of your own. Sort of being one who *have a problem for every solution*.

You may have been injured in some way previously. It could have been on the job or in your personal life. You may have been passed over for a promotion or you began to feel taken advantage of in some way, feeling inferior, humiliated, or are just plain negative person and this is percolating into your professional life.

(Caveat - these are all written with a hint of sarcasm). Modified from *Ron on churchleaders*)

Taking responsibility, being knowledgeable, genuineness (or the sound of it) and authentic communication on your part will cut through much of these. ("To thy own self be true." - Polonius, *Hamlet, a Greek philosopher).* Do the right things. Act in a way that is congruent with your true character. Act with integrity. Be guided by your heart.

The rest will take care of itself. While attempting to be one way at work, while your "true" personality and character emerges outside of work do not be shocked or confused when your colleagues don't trust you, don't like you, and can't really wait to do without you. Abraham Lincoln put it this way 'Believe in yourself and everybody else will believe in you'. Kevin Kruse covered some of these points on *Being Authentic.*

Being proactive is a habit formed by everyone who takes on responsibility - one who needs to be 'response-able'. According to Stephen Covey - a leading American author/an authority in leadership; Proactive people recognize that they are response-able. They don't blame genetics, circumstances, conditions or conditioning for their behaviour. They know their behaviour is a product of their choices. Reactive people, on the other hand, are often affected by their physical environment. They instead find external sources to blame for their behaviour.

The blame mentality, if correct, should declare that nothing good or bad is ever our own fault. But Winston Churchill said that 'responsibility is the price for greatness'.

Covey further grouped the challenges/problems/opportunities of everyday life into two: Circle of Concern and Circle of Influence. Proactive people focus their energy and time on things they can control (their circle of influence) Things they can do something about: health, problems at work etc. The Reactive people focus their efforts on things which they have little or no control over (circle of concern) e.g. the national debt, terrorism, the weather etc.

A lack of congruence between personal and professional values creates a reality gap that is obvious to team members. Porter-O'Grady & Malloch (2015) linked authenticity to leadership: That the success of the leader is more closely linked to personal authenticity than to a particular leadership style.

Discovering your life purpose in your work is important. The career we choose ideally ought to be best possible medium to share our life's purpose with the world, but it is also true that for many people, a career change is about the most important learning experience in life. Though it was a leap of faith mostly, it should also make financial and logistical sense. This was what Amanda Carrado said on The Muse *Career story* on April 5th, 2017. She changed from being a financial analyst with JP Morgan Chase to become a recruitment consultant specializing in talent acquisition.

Real talk

According to Bishop Allan Kiuna who runs a column 'Real Talk'-:'The future truly makes all of us, regardless of current or past status, we are subject to the hope and mercy of tomorrow. He added Life will always be difficult if you are always trying to start all over instead of confronting obstructions and oppositions on your one resolved journey. On your single straight and narrow path towards a single destiny. Legacy has an irreducible minimum: never operate on your second calling! Your primary call is your lifeline and your source of life'.[*Real Talk' The Nairobian*]. I believe the bishop to some extent because one thing remains constant about every career and that is – human nature. Wanting to excel, being valued, going beyond the limits of oneself if that is what he meant.

As I concur with the above, I believe we all have points in our careers that don't go as planned, yet we would like to feel better about where we are going. Do you ever wonder if "this is it"? Yearn for greater meaning in your work? Getting too busy (or too bored) wishing life was more exciting. Every you speak, all that people heard was nagging and whining. Actually begging their attention. Albert Einstein once said the thinking that got us to where we are is not the thinking that will get us where we want to be.

For many people, the turning point was when something terrible happened in their lives, their career and so on. You think you will never be happy when you are in a rut. It is when you are there at your darkest that you need to grip down and try your hardest. If you do not see any of these possibilities but keep seeing progression of the end, not even a fair compromise to overcoming your limitations, even one step at a time, then it would be about time to do what we call in Kiswahili *'jiite kamkutano'* or self-evaluation or rather REFLECTION +ACTION=CHANGE. May be all you actually have to do – LISTEN – to yourself. Really getting down and really thinking about it. There is nothing as great as that moment, 'I came to a moment of pure realisation one night, at about 2am'.

The simple decision that this was no longer what or who you wanted to be. Or otherwise woo-ing your chosen career path back and see how it would bloom - just because of a change in your attitude. Give it the time and affection and attention it deserves. You realise that you miss the best years of your career can but you only see this now. Do not be surprised if you begin glowing with happiness..

Stephen Covey, recognized as one of Time Magazine's 25 most influential Americans and an acclaimed world top leadership authorities wrote in '7 habits of highly effective people' that there were 3 constants in life: change, choices, and principles. Some who followed these had something to share, 'I was giving to myself the advice I needed', 'See the causes of my frustration', 'Once I knew these causes I could act upon them' (in the words gleaned from Julio Peironcely Ph.D).

Covey continues, 'take a moment to think about your life now. Are you right-now - who you want to be, what you dreamed you'd be, doing what you always wanted to do? Be honest'. Sharma (1997) cautions that there is always the apparent risk that came with self-examination and soul searching. Some people even quit jobs that had stifled their progress the moment they discover the true purpose of their existence. But let's put another way - is there a risk in discovering yourself and the mission of your life?

Making a concrete decision from the very core of your heart that your life is more than the sum of your present circumstances and becoming the very best you can be is life's most noble pursuit. "The purpose of life is a life of purpose." Robert Byrne. Stephen Covey, on the other hand, wrote that *if your ladder is not leaning against the right wall, every step you take gets you to the wrong place faster.*

As long as you do not lose focus on where you want to go, expect change to happen and look for it. At times trust your basic instincts to sense and make sense of when a change was going to occur and be ready to adapt to it. It can mean more than one process of going around, under, over or through the challenge in order to adapt.

One can even believe in something illogical if need because 'imagination works and walks'. What was your moment? It may have been an offshoot of something you were doing as part of your career or off work. If only to encourage ourselves, it's advisable to leave the status quo. Better that than the fear, the empty feeling of resisting change.

Consider some words drawn from Robert Frost's (1874-1963) poem ***The Housekeeper*****:**

Strange what set you off
To come to his house when he's gone to yours.
You can't have passed each other…
Though what good you can be, or
anyone -
Its gone so far…
Been there for hawks since chicken-time.

Our mind is capable of imagining things, the likely ones being irrational worries and fears – even scaring oneself to death. The opposite is true our mind can imagine exploits, surprising everyone
- even astonishing oneself. Therefore, move along! Let go and trust what lay ahead. 'Chances are
there, What if you make it? So I look at the - what if?'- Caleb Karuga in *Young Rich*. It may do you some good, God knows you need it. 'Do what you would do if you weren't afraid?'(Quote from *Who Moved MyCheese?* By John Spencer).

Let us start becoming what we are meant to be by developing our potentials and living purposeful life within our profession and beyond. "It is not a profession that makes a man; it is a man that makes a profession." Show some leadership wherever you are instead of complaining.

> "Competent nurses who refuse to play roles in processes that produce nursing leaders are more dangerous to the profession than incompetent nurses who emerge as leaders but lead poorly."
>
> This was gleaned from *leadnurseafrica* wall on Facebook by Collins Ogbolu posting on 17th September 2016. Adding that it was more profitable for nurses to FOCUS on how they could contribute to the growth of nursing individually and collectively.
>
> You might begin to realize that the 'sterile' world of nursing that you had grown accustomed to had: dulled your creativity made a hardened sceptic out of you; limited your vision; felt more exhausted than empowered or more cynical than self- renewed.
>
> Ask yourself: what dream of your life is waiting for you or was it more of the same pain? It could not all be about frustration tolerance which is usually as a result of the fact that some

people went into nursing expecting one thing and become disenchanted when they receive something else.

Being cynical with an 'I can't' attitude hinders many things in terms of progress. The minute you believe something is not possible then it's not. Patience is a virtue in career life. The saying goes that 'Rome was not built in a day'. We could also put it another way – 'Rome was not built with stones but it was built day by day with vision'. While there might be things we could do to accelerate our tomorrow's growth today, we need to do our own growing one day at a time in most aspects of life.

Philosophical insight is a distinction that drives purpose in the profession. Thinking through the philosophy and historical backgrounds of nursing or in general the caring professions helped many people to form an informed choice that has kept them focused independent from prejudices. They were likely to be more autonomous in their judgement.

One therefore ceases to be 'a mere' nurse (if you allow me to use it), but means it. It was not that waves of doubt can't reach them but their habit of mind makes them better nurses. They were also given to theorizing about certain experiences in nursing. They are likely to initiate constructive discussion, explain what they meant.

Seek to know the truth, try to make sense of certain issues, reading widely for pleasure and self improvement, look for evidence etc. They take networking, even by correspondence seriously. These are some of the values that have seen nursing grow to become what it is.

Every other professional trying to make a difference somewhere will tell you they faced frustrations, 'Frustration is always there somewhere …'- General D. Opande, Commander UN peace keeping mission to Liberia (UNMIL)[71]. It was commendable that even having gone through that his team managed to disarm over 40,000 rebels in less than 1 year. Normalcy returned and for years to come Liberia moved from a failed state in 2003 to what it is today.

Those who enter health care profession(s) for love of the profession often found that the money followed their choice naturally. This was exemplified by Stacey Ryan MSN, RN. Quoted in *Five reasons to consider a career as a home care nurse*' appeared on June 15, 2017 in *Nursing Notes* a platform sponsored by Johnsons & Johnsons: '…they were destined for that profession …. they were nurses through and through … they wore it like an identity.'

As a nurse, it was important to identify early enough what was important to you. Might be you identify with a specific area of nursing in which you had always wanted to work. Maybe you want to be just a little more adventurous, move to another country, meet new people and explore new things. What of those projects that you've fantasized about doing "when I have time"? Maybe you just want to go on some holiday.

What of spiritual reconnection with a being bigger than yourself? It can be quite reassuring. Investing in yourself is the best investment you will ever make. It will not only improve your life, it will improve the lives of all those around you. It is not however advisable to make any major life decisions like quitting your job until you've recovered from compassion fatigue (physically, emotionally and spiritually).

Wait until you can see things more clearly. In our settings having an up and going plan 'B' as a nurse is never a bad idea especially if you are on employment, what you would do if you found yourself jobless tomorrow. C, D, E, F if you can for softer landing just in case. However, that is no excuse to do your employed job without the gist and energy you used to have.

71 *The Untold Story,* KTN News, 26th August 2017.

> As a nurse, you would be imbalanced if you are unaware of all the wonderful avenues available to nurses. One nurse commented 'you can do whatever you want with it: be it – bedside, teach, conduct research, manage programs, write books, blogs, work with health care organizations, insurance, non-governmental organizations, school health, work for the central government, county government, pharmaceutical and non-pharmaceutical med products representative, or open an agency/consultancy/private practice etc.'

The world of work is full of tangible advice, people who have moved on in life, some after serious setbacks. Each of these ought to be treated as a learning experience, 'You should never be afraid of the learning curve, you will do some mistakes but learn from them and move on' - Caleb Karuga in *Mkulima Young: Champion of the week*.

Think BIG, start small, Start NOW! You can work full-time, part-time, float/pool, contract etc. Hands-on direct patient care, otherwise known as bedside nursing is the core of caring work. It has some unique characteristics: - it is more available, is a key driver in the healthcare industry, had variety, specializations, often times paid better and was more flexible.

This was where the majority of nurses worked and chose to remain. It is also the best place to begin no matter what other avenues one aspires to move into. It is not only a great launching pad; it provides a receptive fallback position. All great nurses put aside some mandatory direct patient care time, 'to remain in touch and in shape'. It is the recommended nurses' lifestyle. Many statutory nurses' bodies in different countries insist on this component for one to be retained in their register.

Stay in touch with what is happening in the region (and the world) around you; it is safer to be aware of real choices. The following examples might help. The first one was an extract from a recommendation note:

> 'He was instrumental in conception, getting the grant to implement two programs - Higher Diploma Critical Care Nursing and Higher Diploma in Nephrology Nursing in 2010. Today the two are in high demand after most of the county referral hospitals opened ICUs and renal units without adequately trained staff.
>
> As the only training facility in Western Kenya, the classes are always overbooked and have a long waiting list. These have become some of the most innovative income generating projects for the hospital. For these we always remember him, we feel honoured to be associated with such a hardworking inspirational nurse educator that he is'.

Apart from teaching other opportunities abound for nurses who wished to cast their nets wide. When you have the courage and the urge to move on up, you might endeavour to dare abroad. An example of a Kenya nurse who had outmigrated might suffice:

> A nurse friend of mine decided to venture abroad in the US; he was an ICU/renal nurse even before leaving the country. The pay check was not bad but soon he got disillusioned. He was not entirely feeling fulfilled, he wanted to find his niche. He finally got it by training as an anaesthetic nurse specializing in spinal and blocks.

There was need to refine their nursing practice to international standards. 'You either go world class or you don't go at all', these were the words of Barasa Mwabe the founder of *Mawanume ni*

Effort interviewed on The Entrepreneur KTN 18.30Hrs, 20th October 2016.

Furthermore quote of the week *Africa Leadership Dialogues:* "There is no such thing as African excellence. There is one definition of excellence, which is, world class" by Yaw Nsarkoh on Pan African TV *AfricaLD show* on Nov 3, 2013. This means we have to endeavour to raise and maintain standards in what we do.

In the new role of carelee, the onus is upon them to address why in his/her opinion (informed by contextual, environment, character factors etc.) the carer could be as satisfied or disappointed about nursing. Many including the carelee could admit having passed through this phase more times than they would wish to confess.

My testimony

For this author it took so long before coming up with the brands carelee and compleat nurse. For him, it has been 26 years in nursing (21 of these at the operational level or what we call bedside nursing), and the struggle never really goes away but you just learn how to handle it. After transitioning from one aspect of nursing to another over the years I know better. I still do 16 hours of clinical work per week but mainly as I mentor the undergraduate nursing students.

I worked mostly in public health facilities with only a short stint in some private hospital and a glimpse at the US as a student. I have had the opportunity and privilege to see health issues from a variety of perspectives.

Many times I struggled with meaning and burnout just like many other nurses I know did. In those 20plus years I have seen and worked in shortages both at the bedside and in management positions. The longest time in my career was as a backroom staff: I delivered babies for hundreds of women, took directions and orders at the bedside etc. In the years as a nurse manager, I implemented policies and protocols, worked on and implemented hospital based nursing courses. But my main concern was always taking care of 'my' nurses and having their interests at heart. I tried to ensure that essential resources and support were made available to them. I helped create support groups among staff. We held frequent come togethers and debriefing sessions. The most critical period was the nurse manager phase, they were my best years as a nurse. There were so many challenges but looking back I see I had some great times, like this was what I was made for, though I did not realise it then…

But like many a nurse knows, a life long career at the bedside is a thing of the past in today's healthcare environment. In resource-constrained settings especially, it can suck the life right out of a person (My 2 cents). This does not mean that this author advocates that nurses leave the bedside. Not at all, on the contrary the bedside is the backbone of nursing, but it also breaks a few bones. One needs to know how to balance - when to hang on, when to take a rest from it or when to leave all together. Do not just walk out, not yet! Whatever choice you make remember that once a nurse always a nurse.

Having got my MSN from University of Colorado Denver, US I believe that I have the best of both worlds. Nonetheless, as a student of health systems and health policy, I believe I finally found my niche.. Many of my opinions are still forming and I soon found that the one way of going around these was by asking questions. It has taken time, long enough to be relevant and hopefully make a contribution. My focus now endeavours to unravel and explain this phenomenon in as far as its limit permit. Perhaps suggest solutions whenever I can. My background as a clinical nurse, leader, educator, researcher, compleat_nurse] provided a lot of fodder for my projects. I am all eyes and ears everywhere I go. It gives me so much energy that I have something to look forward to every time. I push myself to look into what else, where else, whys and why not's. The motivation? - I realized that once I made a clear decision to blog, focus on this winding path, opportunities seemed to appear from out of the blues.' [http//:www.compleathealthsystems.com] [smk]

For nurses who saw these changes coming, it was an opportunity like no other. It presented many real choices. It is important to be open-minded enough to learn something new, act differently and adapt in time in order to succeed as a compleat nursing care provider and collectively as an organization.

Napoleon Hill wrote in his book *Think and Grow Rich* that he believed: 'whatever the mind of man can conceive and believe, it can achieve'. In other words what you are looking for could be looking for you. As such it was important to be prepared for good luck by: connecting dots, have the needed openness by constantly learning the needed skills-sets for the marketplace.

Unfortunately, the nurse must overcome the victim mentality, the following from *leadnurseafrica* posted on its wall Facebook on 17 September 2016 stated in part: The common experience an outsider *might* have after interacting with an average African nurse is the litany of problems in Nursing, those behind the problems and how all of them have worked together to "Frustrate him/her" Echoing Florence Nightingale who said; "I attribute my success to this: – I never gave or took excuses. "The biggest enemy of progress among AfricanNurses today is habit of giving excuses over personal and professional setbacks".

What about the family? The best gift you could ever give your children is your love. Few things are as meaningful as being a part of your children's childhood. Get to know them again. Take the time to watch them grow and flourish. Show them that they are far more important to you than the fleeting rewards of your professional career. Don't miss the forest for the trees. Sharma (1997) asked – 'What is the point of climbing the steps of success if you have missed the first steps of your own kids?' Live your children's childhood.

The rituals you do together mean a lot more than the overtime cheque at work. The money, as usual, you will never get enough of it, but the honoured rituals' together with family memory are invaluable, remain forever. Parenthood slips away fast, because sooner than you realize children will be all grown up, up and about looking out for themselves. A nurse never ever forgets the gift of family. It is a choice one has to make. Make the decision to spend more time with those who make your life meaningful.

No matter what your dream for your life is at this down moment, memorize it. Write it down. Share it. Embrace it. Do research on it. Plan it. Rehearse it. And make it happen! That means as a professional you are getting somewhere. Oprah Winfrey, the highly successful talk host said "(N)o matter what challenges or setbacks or disappointments you may encounter along the way, you will find true success and happiness if you have the only goal, there really is only one, and that is: to fulfil the highest most truthful expression of yourself as a human being."

Going back to my pet subject - the compleat nursing care provider that we envisioned earlier. This is a future-now and not a yester-today person who: even when they see a challenge bigger than they can handle, they see it is not bigger than they can manage.

One who is an expert at workaround: a method for overcoming a problem or limitation in a program or system. Reminded me of Steven Spielberg's movie *Back to the future.* In resource-constrained setting no matter how hard things get or how badly the 'compleat' nurse is pushed to give up, they look up, look forward and keep going. Look around and say - there is always something to use and do not want to look for excuses.

They have goals that energize their lives. Believe what has to happen in their career life has not yet happened while enjoying the special moments that every day offers because - today, this day is all you have.

Living in the fullness of each day and hope for what will appear in your future is what gets them out of bed in the morning and what keeps them inspired through their days. Knowing they might trip over stuff they weren't even looking for, which surprisingly becomes more than they expected, it could even be worth everything they have been looking for.

It has been said that you can change your life with a single idea - if it is the right one and as long as you take action now. Start off small, but start now. Every day, take some action to advance in the direction of your goal.

The evolving trend in management had sort of replaced hierarchy with networking, demanding that bureaucratic systems be more flexible, replaced control based management with relationship building, featuring empowerment and coaching (Bartlett & Ghoshal, 2002). Relationship dimensions: Internal (personal), horizontal (interpersonal), vertical (leadership).

The Carelee thus believes in networking, reaching out to people for ideas, perspectives and different forms of support. Those who will selflessly serve others, wake up the aspirations of everyone else, including those who are tired of the status quo and clients/patients who have no voice. Fortunately for some of it might include embracing a global perspective.

The orientation in nursing needed to work for them by refraining from viewing new expectations on nursing with old lenses. The longstanding deeply embedded 'matronly, big sister/brother, mother superior' culture was the accepted way of doing business in nursing.

They tended to be more task oriented than people oriented whose functional goal was about allocation and effective utilization of staff nurses. We need to see our staff as a work in progress by creating value in them with a sense of purpose, embracing positive appraising and constructive criticism. Inject meaning into individual effort.

Help them to explore newer, less typical, less traditional approaches to doing things. Literally, bring out vitality in them. Help them reconnect with each other and with the goals of the organization.

A panel of student nurses' perceived intolerance and intimidating behaviours by some qualified staff who must be avoided (Porter O'Grady & Malloch, 2015). This report had analyzed various findings noting that there was need for nurses to care for each other just as they did for their patients. Unfortunately, it has been said that 'nurses eat their young' and indeed in nursing the nurses (staff nurses and nurse managers) and not non-nurse co-workers have the greatest impact on nurses' stress. In this regard, nurses could be/were their own worst enemies and consequently the solution to many of their problems maybe lay within nursing rather than outside it.

"Breaking from the status quo means taking action, and when we take action, we take responsibility, thus opening ourselves to criticism and to regret." A choice quote from J. Hammond, R. Keeney, H. Raiffa in *hidden traps in decision making* (Harvard Business Review, 2011), a PDF may be available online. Another one that I might recommend for those interested in going a step further into self-discovery and making smart choices.(see **we are now leaving status quo** below):



(Mural courtesy of Harvard Business School)

A short African verbiose illustrating how a lacuna that perpetuates the status quo was upheld. Told of a mother (*sic*) who was conversing with her daughter (*sic*) went like this:-

Daughter I: *Why do you always cut the tail of fish before cooking it?*

Mother I: *Because my mother always did so*

The daughter I: Why?

Mother I: *I don't know, may be we need to ask her*

Daughter II (alias mother I): *Why do you always cut the tail of fish before cooking it?*

Mother II: Because my mother always did so

Daughter II: *Why?*

Mother II: *I don't know, may be we need to ask her*

Daughter III (alias Mother II): Why do you always cut the tail of fish before cooking it? Mother III: *Because I had a small cooking pot.*

According to Dr. John Kithaka[72], the founder, Chief Executive Officer of Fountain Enterprises Program (FEP), whom I recognize as a mentor in many things, "My dream for Kenya is for people to identify their purpose and utilize their talents and gifts to exploit that purpose… people strain to make money and work in jobs they don't enjoy, yet it would be much easier and enjoyable to do so in the area of their calling". Dr. Kithaka is a motivational speaker on entrepreneurship and empowerment,

Fred Machoka, a renowned Kenyan media personality was interviewed in the program *Jeff Koinange Live*[73] christened *The Living Legend,* 40 *years later* added "enjoy what you do because
if you don't you will have a long day… Do what you enjoy doing, and get paid for it."

The secret of happiness is simple: find out what you truly love to do and then direct all of your energy towards doing it. … then find someone who will pay you to do it. Once you do this, abundance flows into your life and all your desires are filled with ease and grace.

If you study the happiest, healthiest, most satisfied people…, you will see that each and every one of them has found their passion in life, and then spent their days pursuing it. This calling is almost always one that, in some way, serves others (Sharma, 1997).

[72]Parents issue, No 335 June 2014: Inspiring Lives. www.parentsafrica.com

[73]KTN Jeff Koinange Live, 22 Hrs, Thurs 19th March 2015

'To do what nobody else will do, in a way that nobody else can do, in spite of all we go through... that is what it is to be a nurse' ~Rawsi Williams Tweet

> **Career Burnout** *'This is important especially if you realize that you have turned into a hard, mean, unapproachable nurse who only had moments of light-heartedness. Feeling angry and exhausted at the short staffed unit, sick of hearing No all the time from management, and for years you took hit after hit and never repaired the damage'* (these were comments I found valuable, made by a nurse I was networking with online in response to the importance of understanding burnout among nurses). She added *'It was at this moment I made my career change from the adult world to the children's arena and have never looked back. I have had to work to regain the love I had in nursing and get rid of my negativity toward healthcare. It took a long time of self-reflection to learn where I had lost my way and what I needed to do to regain it'.*

In whatever capacity that position may bestow unto us, it is only human to appreciate that it is indeed a privilege being there doing the needful for the patients during their time of need, so it would be best to serve them with humility, honour, and dignity.

A compleat health care provider by looking for new ways creating energy for themselves and their workplace will want to leave behind an enduring legacy, a system that outlives them. If indeed it's a true saying 'we have not inherited this land from our ancestors but we have borrowed it for our children'. This outlook does affect the quality of health care delivery a great deal.

The carelee is an advocate for the nurse's cause. It is about time we dignified the lives of our nurses in Kenya. We do not have time to waste time. A better life for our nurses is better health for our health care sector; no more no less.

The managers are there to ask if there's anything the nurses need to do their jobs. It is not being self-grandiose or anything, but if we took the largest health profession in the country and raised up their capability of providing excellent care through education, welfare, and other niceties you would most likely get better outcomes (Burnes Bolton in FierceHealth *eBook*, (2014).

Even if those needs were as simple as replacing a broken glucometer, providing sustained support from management and leadership is crucial. This might mean having managers who will conduct routine rounding on staff, sometimes on entire departments. Unfortunately, this has not always been the case, there has been marginal managerial attention focusing on problems of employee's capability and motivation (Bartlett & Ghoshal, 2002).

It was not good enough that some positive change was witnessed when you have a great and supportive manager one who had the ability to get things done. Only that such change rarely outlived them, it was unfortunate that for many resource constrained settings it was more to do with management capabilities of persons vested with responsibilities to manage and not having any superior systems in place.

Individuals, networks could fatigue but institutions did not. Therefore it was better to fight to have strong institutions, systems, frameworks, models etc. Strengthening them included funding them deliberatively and affirmatively to enable them to do what they were mandated to do. Strengthening bodies and persons meant supporting their mandate, giving them power, instruments, space and trust.

'Hospital administrators need to take the time to listen to nurses - the core of hospital bedside care and not just look at everything on a spread sheet in order to handle the economic downfall'

(Lee & Anstead, 2010). Sometimes managers and administrators get caught up in the numbers that they forget the basics and how important nursing is to the overall bottom-line.

"No one is sitting in an office, evaluating data and telling nurses what to do," said Mike Swanicke, a management engineer on the Performance Excellence Team. "We're working together to solve problems." *Run your Nursing Department Like a Business* University of Utah Hospital.

Patterson *et al.,* (2012, p11-14) described tools for talking when the stakes were high in what was referred to as holding crucial conversations. Crucial conversations were characterized by high stakes, strong emotions, and opposing opinions. How we each handle those moments matter a lot towards our joy and fulfilment in the workplace, ultimately the productivity of the organization.

Unfortunately for many such situations 'when it matters the most, we do our worst'. Or else employees fell silent when crucial moment's occasion. In their research they were able to document that in organizations where employees voiced their concerns their endeavours were less than half as likely to fail. These means that there are serious performance indicators that could be linked to relational communication in the workplace.

When fighting for others rights, those others must be seen to be behind you also. Unity across the ranks in nursing was paramount. Lately, the unity has held, brought some gains and also some not so good results. This author's observations were that caring in Kenya has not suffered such volatile and uncertain moments as now.

Out of the hard times a number of no-nonsense personalities who could handle anything emerged; a crop of nurse activists and advocacy leaders who after marginal success were known to regroup and return, since as they said it 'they were not asking for a favour' its until they got what they wanted. Words came easily for a number of them.

They often intimated that they were running for something and not against anyone. Anything accrued to them in the process was with the interests of the nurses (and by extension patients) at heart, so they said.

Hospitals in the Kenya need to address nurses' concerns early before strikes seriously undermine patient care. Apparently, somehow it was becoming more of a reality in Kenya especially that some compromises and gains could not have been achieved without the threat work stoppage or a strike. Why had this become necessary in our settings?

The Kenyan case fortunately or unfortunately demonstrated to a significant extent the need for long-term efforts to support nurses (albeit through resilient union campaigns - a not uncontroversial partner), to overcome the political sclerosis typical of so many African legislatures. Or could it be as the late Chinua Achebe wrote – paraphrased from *Things fall apart, 'As* a man dances so the drums are beaten, Mr. Smith danced a furious step, so the drums went wild'.

The tempo had been upbeat with the advent of the county health system. The county bosses or the health care providers were not in sync. The Salaries Remuneration Commission (SRC) governors were complaining rather loudly for healthcare providers' comfort about what was a perceived right e.g. disparate pay perks, 'hefty allowances medics earn', study leaves etc. These were perceptions the medical fraternity were not taking lying down. This was regrettable and

most unfortunate considering that the most affected would mainly be the vulnerable and needy members of the society. Consider the following examples.

Barbara Schutt (then editor of the American Journal of Nursing) wrote concerning industrial action. This was soon after delegates to the American Nurses Association (ANA) in 1968 did away with *No-strike policy*, '… few nurses will use strike weapon easily, and if they do, they will use it responsibly - with adequate notice and plans to provide emergency care'.

This observation was becoming a remote reality, especially in Kenya. Strikes had changed from the rare exception to become the common norm in recent years. No need to explain that here, since activism was never the primary intent of this book but rather factors that would allow us to interrogate the quality of health care provision in our settings (see **#HealthcrisisKE Diaries** in Chapter 3).

Article 41 of the Kenya Constitution and labour relations laws spelt that: workers could express their rights to go on strike as one of the avenues when their rights to better terms and conditions of employment are violated by employers. Further, during an industrial action striking workers take directives from bonafide officials of the union only… Could these legitimate expressions have been overused of late (2012-2017)?

May be there was need to safeguard against strikes and lockouts by health care workers. On 60th and 129th day of the nurses' strike the Federation of Women Lawyers of Kenya (FIDA).

On 1st August 2017 FIDA went to court asked the attorney general's (AG) office in 90 days to file a bill to come up with a law that would mitigate the effects of industrial action affecting essential services workers.

In its submission filed under certificate of urgency it demonstrated that the respondents had allowed the strike to prolong with no hope of calling it off. It agitated for an order to compel them to sign the CBA to be signed and filed in court in 7 days. On 11th October:

> *A Case filed by FIDA asking the Industrial Court to compel KNUN, COG, MOH and SRC to complete Nurse's CBA by signing and registering the CBA in court, was heard by Judge Nduma Nderi... COG, SRC and AG representing the Government gave their submissions and determination of the case will be on 8th December 2017...*
>
> *In another case filed by KNUN at Nyeri Court: Meru, Kirinyaga, Mandera and Lamu counties have been ordered NOT to hire to replace striking nurses until the case is heard and determined as indicated below:*
> *Cause No.384 of 2017. ORDERS :*
> *1. Application Certified Urgent.*
> *2. Services upon respondents by close of business tomorrow 12.10.2017.*
> *3. Inter-parte hearing on 18.10.2017.*
> *4. Pending the inter-partes hearing of the application, the Respondents herein are RESTRAINED from proceeding with RECRUITMENTS, SELECTION and APPOINTMENT of ANY Persons towards replacing the Claimant's members in the respective employments and more particularly as a consequence of the job advertisements by the 1st, 2nd and 3rd Respondents respectively.*
> *5. Cost in the cause...*

This was not the first time such a petition was coming concerning essential services if one remembers the Petition70of2014 by bigwig activist Okiya Omtatah Okoiti. It sought among others *...there is need for the state to enact a legal and policy framework to secure the rights of workers in essential services, and to ensure the amicable resolution of Labour disputes without disrupting service delivery*.The petition was dismissed by Justice Nduma on 8th day of December 2015.

Nevertheless, *The User Guide on Employee Relations for the Health Sector in Kenya 2016* said in part- no one should take part in a strike if engaged in essential services as health. This policy yet to be enforced exhorts workers to draw a line between self interest, politics and professionalism at all times.



Pic: A recent demonstrations by nurses on day 125 of the longest strike that lasted five months (Photo courtesy of *Precision Nurses* wall on social media)

The Bill of Right is entrenched in The Constitution Article 41 (2) (d). The bill of rights provides for industrial action among other things.

However the Labour Relations Act 2007, section"81": Essential services
(1) In this Part "essential services" means a service the interruption of which would probably endanger the life of a person or health of the population or any part of the population.
(2) The Minister, after consultation with the Board—
(a) shall from time to time, amend the list of essential services contained in the Fourth Schedule; and
(b) may declare any other service an "essential service" for the purpose of this section if a strike or lock-out is so prolonged as to endanger the life, person or health of the population or any part of the

population.
(3) There shall be no strike or lock-out in an essential service.
(4) Any trade dispute in a service that is listed as or is declared to be an essential service may be adjudicated upon by the Industrial Court.
(5) A collective agreement may provide that any service may be deemed as essential service"

A bill had been tabled in the 12th Parliament in October seeking to secure essential services against the ravages brought by constant strikes and lockouts. It sort of cements want is actually in the labour relations act above but adds tough clauses to deter nonconforming parties.

Just like Petition 70 of 2014 the same argument might be advanced in the pushing of this bill. In as far as Section 81(3) and 78 (1) (f) purports to nullify the right to go on strike provided under Article 41 (2) (d) of The Constitution.

Whereas Article 2 (4) of the Constitution provides that; *"any law, including customary law, which is inconsistent with this Constitution is void to the extent of the inconsistency, and any act or omission in contravention of this Constitution is invalid."*

Fida observed that CBA's in the health sector appeared to be losing their value. There was a need to balance upholding the freedom of workers to go on strike while protecting the citizens' right to life which should supersede the strike.

The gains made by free maternity program, Campaign against malaria, HIV, TB would come to naught if we failed to properly organize manpower. Its manpower that implemented projects and programs. But then when we consider the following posting by A W on Face book wall enlightening Nurses commenting on a (then) ongoing industrial action by nurses that lasted 100days plus '… this opportunity of striking will never come again because I heard the government want to amend laws'

Could nurses cross the picket line to help handle emergencies, with the full approval of the union? The general observation was that many health facilities had literally been closing down during strikes.

However there were a few exemptions, around February 2017, over 300 nurses from the AIC Kijabe Mission Hospital downed their tools, demanding a 36.7 per cent pay rise. The caregivers, who were members of the Kenya National Union of Nurses, also alleged mistreatment by the hospital management.

They had taken the necessary measure to prevent loss of lives at the facility "We don't take chances with our patient's lives. We had agreed that HDU, ICU, maternity, nursery, the emergency ward and all the critical areas were working normally," The AIC Kijabe Mission Hospital had in its intents and purposes worked more as a 'tertiary' hospital of its own kind, receiving referrals and performing class super-specialty surgeries.

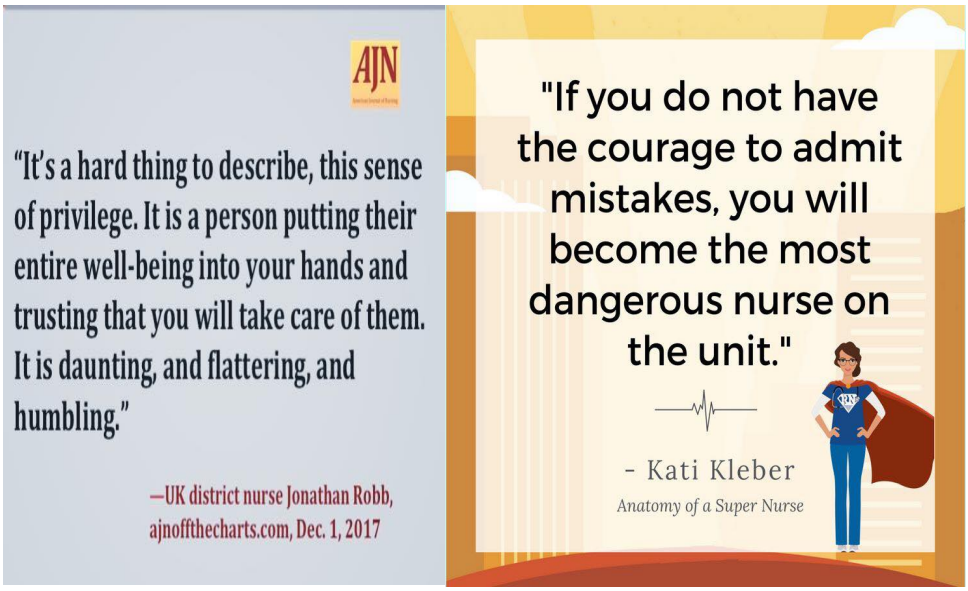
Many sub-Saharan African countries did not have a

A strong lead agency for health care workforce (might be comparable to Teachers Service Commission of Kenya). Rather, responsibility for staffing, personnel emolument, equity, promotions, and welfare was divided between numerous governments' bodies. For Kenya, these include the recently constituted Salaries & Remuneration Commission, directories in the Ministry of Health, Public Service Commission, and Counties' Public Service Boards. Piecemeal efforts and communication between these different commissions, departments, and agencies often were poor. Perhaps this did not have to be the case if the much touted *Health Service Commission of Kenya* was effected.

Point to ponder

The following was what President Paul Kagame of Rwanda said in a National Prayer Breakfast:

"Do not be afraid to face our challenges head on. If you don't work hard and fight hard to be at the table, you become the menu ..., you must fight to be at the high table. We have been items on the menu for too long ... No one owes us our livelihood and we do not owe anyone our livelihood. Working towards the achievements we deserve should not be a one-time and a way of life. ".



Some wise observations above (Courtesy of Robb and Kleber)

'Success is liking yourself, liking what you do and liking how you do it'- Maya Angelou (1928-2013). Maya was an accomplished American poet, memoirist, civil rights activist, author (7 Biographies), and dancer. But she was more than all that (http://successstory.com).

She wrote this concerning her mission: *'My mission in life is not merely to survive, but to thrive, and to do so with some passion, some compassion, some humour and some style'. 'Pursue the things you love doing , and then do them so well that people can't take their eyes off you'.* Some of her works include:- 10 rules of success, Live the life of your dreams, have the courage to begin, loving life and daring to live it.

Often times official statistics showed huge inconsistencies - and in some cases appeared like 'copy-and-paste' from the previous year(s). Figures concerning patients' workload, pay checks, leverage increased funding for staff were not always be accurate.

Data from staff unions and the official position often showed astronomical discrepancies. Lack of data could be used as a reason (or excuse) for inaction. This meant that there should be someone to question the data behind decision making in many cases, to question if errors in some of the data came as a result of incompetence or wilful manipulation for whatever reasons.

Without accurate data, it was impossible to develop effective interventions, and it was impossible to evaluate the effectiveness of those interventions that are in place. Even researchers were at times hesitant to rely on the secondary data available from some government sources to accurately quantify some of the problems.

The Nursing Council of Kenya should be commended for leading the way in terms of possessing an updated *e*-database of nurses in Kenya, but more needed to be done.

Literally speaking, everything matters to the carelee. Why, because the carelee belief was that nurses do and can enjoy doing what they did. It was a commitment not only articulated in clear human terms but also reflected in the daily actions and decisions of the carelee as a nurse leader. They were passionate about the need to help, literally searching out the afflicted nurses.

That means that we need to advocate that employers should invest in their employees (in this context nurses) because apart from the patients, they're the second to none reason for the existence of every hospital.

Taking note of this observation from one public hospital - A hospital's first priority was to treat the injured and the sick as they present; *while it was acceptable for a clinician to see five patients in a day - and spend 3 minutes on each, why doesn't it seem odd that a nurse must attend to more and spend more time with each?*

This argument was based on solid evidence, emphasis made by Burnes Bolton in FierceHealth *eBook*, (2014). Nothing could be truer about nursing in Kenya than the above comment.

The fact that Kenyan nurses were still standing was borne out of their resilience, they are not yet where they are going but things are not as they used to be. They were a good example of the saying that *persistence eventually wears out resistance. That together united we stand* but *those who fail to stand together in unity fall together in disunity*.



Pic: Together in unity (Courtesy of anonymous photographer)

Evidence showed that the world over many treatments in hospitals was administered by the nurses who were clearly in control of the milieu. Forget the rotten apples; nurses were the heroes of health care. Every metric on which hospitals (and healthcare for that matter) were evaluated - from quality outcomes; to safety; to patient satisfaction; to staffing efficiency; to medical staff confidence - were dependent upon having a staff of nurses who felt valued on the job (Mitchel 2009) (see Box 1 below).

Nursing was not the only indicator of patient satisfaction but it was indisputably one hospital service having a direct and strong relationship with overall patient satisfaction. Quality health care requires a nursing workforce appropriate in size and expertise and unconstrained in its ability to provide patient care safely. This observation was made by John Mitchell. Mitchell received the. "Top Leadership Team in Healthcare for Mid-Sized Hospitals" (*HealthLeaders* magazine in 2009) also (see **Informal leaders** below).

The carelee role will never be something any outsider can help us do, it is a relationship that needs to be nurtured. The carelee will need to understand the changing times. Taking on the role of a carelee of the carer ought to be something many will be willing to take on in order to absorb the disappointments, frustrations, disillusionment and breakdowns that some nurse somewhere could be going through.

The compleat nursing care provider can call up, shout out to, beckon, get a referral, look up and there will be someone to walk by them upstairs and rest with them on the basement, remind them that the way down is quicker but not necessarily easier.

Enjoy the cool breeze of the balcony together but remind them we cannot be there long. Help with picking the cane that fell off. Once in a while be with you down there as you recollect yourself and pick from where we left. If only we could react proactively rather than proactively to diffuse the adverse effects of caring o the carer.

Informal leaders

Nursing center *eNews* April 2014 advice to nurses:

'…be a nurse leader, no matter your role or setting, leadership qualities are important for us all to demonstrate'. Leadership is based on individual characteristics, approaches to situations, and ability to handle change. It is up to nurse leaders to adjust, adapt, and look for ways to highlight the talents and traits from each of the generations.

Nurses who feel valued can have a profound effect on the environment in which they work as well as their feelings toward the organization in which they work. While administrative leaders are needed, so are informal and formal leaders at every level and department and these need to be recognized'. Nurse leaders are in the best position to advocate for the types of system and payment changes that capitalize on the contributions of nurses. According to The Francis Report 2013 *'…we must stop underestimating the importance of kindness and compassion, the fundamentals of good patient care that cannot be budgeted for.'*

Why, because there will always be ups and downs of the caring profession. We have not yet discovered another way to it, but so is every decision to be someone's keeper, carer, and carelee. We feel, we react, we sense, we respond, not always the way we would have liked it but it does have a meaning in our heart of hearts - the heart of caring or otherwise *the hurt of caring*.

Cumulatively we often do take it in and not out, and this is where the problem is. Consequently, could be you notice or it had been brought to your attention that you are becoming more prone to a certain tendency to respond with a certain behaviour. We need a carelee in our career's lives. It

is a collegial role that we only can escalate.

We have to give back, dialogue – sharing/growing/filling pools of meaning (Patterson *et al.,* 2012) with those who have been there and seen it all, those in there and those approaching there. The carelee leaves clues and hints - some on purpose, other times maybe not even aware they were doing so. But he knows that he had left a trail for others, in this case, the carer and that carer could find his way if he could just read the writing on the wall.

Mentorship, preceptorship, counselling, reflection have tried but there seemed to be a middle ground in all these, the carelee. We can make it safe for them to open up, share with us what it is that was that was making them uneasy. Never again should nurses 'eat their young'.

They will be mindful to know that there could be someone watching, someone they could come and complain to. I LOVE NURSING wall on Face book, *Tag your mentor* was a great initiative asking members to recognize those nurses who made an impact in their early career life, with a caption '…protect my baby nurse from the rough life of healthcare'. It had more than 1500 (and counting) *comments* and even more *likes* in first 12 hours.

Carelee was not possibly a role with any monetary perks but nevertheless an invaluable one that could be formalized in organizations. Whether one thinks they can or can't, it was a choice that had to be made of becoming a carelee of the carer(s). Giving more of yourself to those around you, whether this meant your time or your energy - your two most valuable resources. The attitude you inculcate might be carried throughout the career life of the beneficiary.

It is a concept that was still evolving and being worked on elsewhere. It is the hope of this author had played the carelee role albeit in a small way through the section we have just covered. Carelee was not always something I spent my time thinking about, infact I started by figuring out the compleat nursing care provider. Blogged about it a bit, including slotting it in nurses' Wikipedia.

But with time I figured out that an effective compleat nurse needed lots of support. Looking at what was it that was missing from the all other supports I realized *carer of the carer* had hardly been touched. Though a bit on the care of carers information was available on lay care (usually the unpaid, volunteer family members to the sick) providers covered in Chapter 14 of this book. It seemed like that there was more on them than on *nurses as carers who needed care too.*

The author also felt that the architects of the concept of Magnate® recognition were carelees. They exerted themselves not by looking for an easy way out but one that gave nursing a chance to foot stamp its authority.

Magnet accreditation was one of the most distinguished profiles any hospital could aspire to in the US. It had been proved that when nurses were given proper recognition, everything else fell into place. 'If you look at any Magnet®-recognized hospital system, you'll find that nurse satisfaction reflects on patient care. Happy nurses are happy at work, and therefore their positive outlook shows in the patient care they deliver along with outcomes', Suzanne Lee & Anstead Pamela (2010) had written several articles on self-care on the part of nurses.

To a lesser extent, carelee could be accorded as an honorary that could also be extended to those who had shown exceptional consideration and acts of kindness to nurses. Consider the *Confessions of a hospital administrator* that have been mentioned in Chapter 17. I believe there

could be thousands of others out there if we were to believe in the genuiness of concerned people who responded to the nurses' petitioning the public and media for respect in the campaign dubbed:

#showyourstethoscope, #JustANurse, #NursesUnite hashtag on Twitter and Instagram in November 2017.

Sharma (1997) summed up it this way, 'By elevating the lives of others, your life reaches its highest dimensions'. Nursing provides one such an opportunity (a higher purpose) that might be lacking in most other careers. It is part of what we do every day. You hardly need to try - just be a little kinder and gentler and have masterly ability to spot a carer who is not handling their patch well, who is about to burn out.

May be this way we can turn many around into a compleat nursing care providers. But each one of us needs to have the right outlook, the new paradigm. In the market place, not every utility car needs to be a Probox®, every motorbike a Boxer® and every jacket (popularly referred to as 'jeket') leather brown.

We too can change our outlook. The outlook could in turn influence policymakers at any level. Consider the following example:

"… My involvement with people with spinal injuries was the beginning of my real life. Before, I lived in a cocoon where I thought that all there was to life was waking up, going to work and going back home." Bright Oywaya, a member of the board of the National Transport Safety Authority (NTSA).

A former banker got paralyzed in a road crash. She has been a leading advocate for legislation to lower speed limits around schools and had taken the road safety message to the global stage. January 2014 she was among the advocacy panel that spoke on a panel at UN Headquarters on the need to include a road safety target in the Sustainable Development Goals. Today we have a specific road safety target to halve road deaths by 2020 in the Health Goal.

The reader will by now have realized that this author had some special liking for 'fables about fulfilling your dreams and reaching your destiny' based on the SagesofSivana' by Robin S. Sharma (1997). This is one self-help literally work that I might recommend.

Also, try www.whitedovebooks.co.uk they are some of the internet's leading website for self-improvement and personal development. While at: www.alt.binaries.e-book sample some of Dale Carnegie's work e.g. *How to Win Friends and Influence People.* It aided me enormously, might I recommend it too highly!? The beauty of it is that these are open source (free) *e*-books. Remember readers are leaders and you will be a true leader once you get into the habit reading, good stuff on personal development, evidence-based practice etc.

17.9.2 Changing nursing care models: Are we there yet?

With all these changes happening in our health care system, the reality of the matter might be just as Abraham Lincoln (1809-1865) had observed, 'It is not "can any of us imagine better?" but "can we all do better?" The dogmas of the quiet past will not work in the turbulent future. The occasion is piled high with difficulties, and we must rise to the occasion. As our cause is new, so must we think and act anew'. What is at stake is now worth more than what it used to be.

There is a mark-up in terms of value in everything we do. The service we have always given will no longer be just work, it is now referred to as a business. Patients are now called customers/clients. Administrators are now called managers.

Staff are now teams. Performance contracting can only be expected to be weighted more, targets escalated and cascaded further down. The age of accountable care has caught up with us. There is no future for healthcare decisions and actions for which there is no functional relationship

between what is done and what resulted or cannot be demonstrated (Porter-O'Grady & Malloch, 2015). Health care leaders will need to get staff engaged and motivated to change and grow in a context demanding a different way of delivering health care. The leader's role modeling in adjustment to change will encourage staff to adapt to change too.

Institutional models of practice, hospital stays and long-term patient relationships will no longer define nursing care. Continuously shortening hospital stays and less need for hospitalization for an increasing number of medical conditions will continue (Porter-O'Grady & Malloch, 2015).

There is now more than ever the need to encourage patients to be active in their care, create some independence, in fact doing everything for the patients is no longer the best way to render the needed assistance. There are many tasks that will continue to be placed in the hands of the patient for his own good. This will call for a change in attitudes, beliefs, and practices because this goes against the traditional "doing for" in the definition of nursing and caring.

Replacing the expectation of "being taken care of" in the dependency model of "doing for" with the expectation of "doing with". In the dependency model, the patients used to surrender responsibility, accountability, and control of the health care provider.

In the new approach, providers must focus on teaching and empowering patients to do more, involve the family members and significant others in the delivery of services for their loved ones in need of assistance. Follow up now means making sure patients can gain access to needed resources, information, home care, social support, network with others of similar challenge(s). Generally, these are not to be found within the health care system as has always been known.

Quality and customer feedback has never been so much a concern as now. The service charters that have oftentimes been taken as a formality will become a daily mark of the quality of service delivered. Indemnity insurance will become a requirement to practice.

Devolution had set off as an accelerated process of political decentralisation more than anything else. The bosses would no longer be on the 4th floor or there about at Afya House Nairobi, but a block away from the operational level/point of service.

It has not been said often enough but it's true that one of the very difficult choice every CEO the world over had to make or failed to execute was - 'to fire the people they should' or rather keeping the wrong person for too long or hiring the wrong person with regrettable consequences. Many human resource specialists agree that one sure way to avoid performance problems is to take the time to hire well.

There was a lot of fear about delivering results among some staff. This might not always be so going into the future. In short, we might need to admit that the good old days were not really all that good, not even as good as today or as good as the future could be. The following incident could be a sign of things to come:

'I will not allow one or two people to paint a negative image of other hardworking officers and to shortchange wananchi, who are hungry for speedy development and quality services," A.M., Governor Machakos County said. He had suspended a medical officer and 3 others in one of his county hospitals. KMPDU secretary general Dr. Ouma Oluga retaliated that the governor "can only ignore the matter at his cost". "It is okay, he can ignore those issues if he so wishes but we will withdraw our doctors if he doesn't apologize within seven days,"[74]

[74] *The Star* Wed, 20th July 2016 'I won't say sorry for kicking out lazy officers', Mutua says https://www.tuko.co.ke/227331-a-passionate-letter-a-doctor-this-a-killer-government.html

The governor had asserted 'I won't say sorry for kicking out lazy officers'. In a letter to the governor, the union faulted the governor for ignoring the laid down disciplinary procedures, while dealing with health workers due to what they termed a "venomous style of handling doctors".

They actually did strike and the story took many nasty twists at one point the medics failed to turn up for the meeting to conclude an agreement between the parties concerned. They accused county governments of becoming increasingly intransigent, disrespectful of medical doctors, political interference with their work, unfavorable working environment among others.

By the time of submitting this book for publication, the industrial dispute wasn't as settled as such. See also countrywide 100-days doctors strike (late 2016 to early 2017) in Chapter 3 that nearly brought the health sector to its knees. The reader might be interested in sampling the 'A Passionate letter from a doctor…' [75]

Ability to communicate effectively in complex and diverse professional situations into the future will include: being in a position to communicate across multiple cultures, generations, and professions; reframing conflict as a diversity of preference, beliefs and values; relationships between differing personal perspectives and the dynamics of power positions Dainton & Zelly (2015).

'As healthcare providers, specifically nurses, we tend to have an innate caring sense. If you come from a place of caring you will find that nursing is universal. No matter the culture you will find a way. I have found that expression has been my best tool.

Having the ability to express and implement quality compassion care has worked well for me.'(This was a comment I found valuable, made by a nurse I was networking with online in response to the importance of understanding cross-cultural communication).

Josephine Campinha-Bacote did a lot of work on cultural competence in the delivery of healthcare services. She developed a mnemonic; "ASKED" that helps people assess their cultural desire, awareness, knowledge, skill, and encounters. It is as follows (Camphina-Bacote, 2003):

Awareness: Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other "isms" in healthcare?

Skill: Do I have the skill of conducting a cultural assessment in a sensitive manner?

Knowledge: Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of bio-cultural ecology?

Encounters: Do I seek out face-to-face and other types of interactions with individuals who are different from myself?

Desire: Do I really "want to" become culturally competent?

As one looks back at their career as a health care provider and evaluates themselves on how far they have come in knowledge, attitudes, and skills. They might also find that they were still

[75] https://www.tuko.co.ke/227331-a-passionate-letter-a-doctor-this-a-killer-government.html
This was in public domain and is used here for learning purpose only with no harm intended.

lacking somewhat in actually seeing out different cultural encounters in order to provide cultural sensitive holistic quality health care.

Self-knowledge of your culture as a care provider is important. When individuals know that you care enough to 'ASKED' about their personal cultural background, it definitely helps to relate to them (Camphina-Bacote, 2003).

Outsourcing of agency float/pool staff will cover for the gaps in staffing. It is no longer cost effective for every organization to hire all the people it needs, and there are seasonal fluctuations too when the demand goes high or up. Through the syndication model, agency nursing is soon becoming a reality in Kenya. A colleague veteran nurse runs such an agency in Nairobi. More established outfits include Kenya onlinepharmacy.



Pic: Fraud, Waste, and Abuse - a junk of out-of-order lie in the open over prolonged periods, some of these items had come as donations usually without spares or technical backup

(Picture used with permission: Community Eye Health *Update 6*)

Job security will cease to be the main consideration in taking up an appointment. Nursing in Kenya would also go the way of other countries where they have one of the lowest retention rates of all healthcare staff. Porter-O'Grady and Malloch (2015) put it this way about today's workers, '…unlike previous generations of workers, they are not faithful to the workplace.

Instead, they are faithful to the work, moving anywhere the opportunity to do it appears'. There are just about four generations in the conventional workplace. This explains intergenerational conflicts namely based on each generations Date of Birth: *Veterans = (1922-1945); Baby Boomers = (1946-1964); Generation X= (1965-1980); Generation Y or Millennial's = (1980-2000).*

There are certain generational characteristics and potential age-based variations that have been studied; this was brought out in a meta-analysis of hundreds of research articles, a sample size of 1.4 million people done by Twenge and Campbell (2008)[76].

Generational management was about understanding the meaning of work for individuals of different generations. The challenges of each upcoming generation are different, and so the best strategy is to create new pathways bridging the generations rather than to expect later generations to conform to the values of the earlier ones (Porter O'Grady & Malloch, 2015).

Point to ponder

'America thrived in the 20th century because we made high school free, sent a generation of … to college, (and) trained the best workforce in the world. We were ahead of the curve. But other countries caught on. And in a 21st-century economy that rewards knowledge like never before, we need to up our game. We need to do more'. — President Barack Obama.

One nurse shared that she has been in and out of one of the big hospitals in Kenya as an employee; she had her 4th personal file number (PF No.) from that institution but one from all the other institutions she served in the interludes. It has become possible to glean past records of an employee e.g. the recruiting team gathers feedback from a candidate's past employers via an online tool called a skill survey (Fiercehealth *eBook*, 2014).

The *HealthcareSource Quality Talent Suite*® software helps healthcare organizations acquire, develop and retain the best workforce possible in order to improve the patient and resident experience. The company's cloud-based talent management solutions include applicant tracking, behavioural assessments, reference checking, employee performance, compensation, competency etc. This means in effect that the dynamics of the workplace are changing.

Chris Hart, a renowned Kenyan newspaper columnist in relationship posted this on his wall on Facebook in the month of December 2014. He said that careers work differently nowadays, no one belongs to an organization for life anymore. There was a need for personal branding, repackaging, re-strategizing making reference to your vision.

Developing and marketing new skills, things you are passionate about (and get paid for it) or just volunteer to do some work that enables you to gain some life-skills or to enable you to meet some new people. The building blocks for 21st century include critical thinking, complex communication, creativity, flexibility and adaptability, collaboration, production and accountability (Source: Iowa core universal constructs). The 2015 State of the Union address focused on topics such as 21st-century skills:

The routine jobs of yesterday are being replaced by technology and/or shipped off-shore. In their place, job categories that require knowledge management, abstract reasoning, and personal services seem to be growing.

[76] Generationaldifferencesinpsychologicaltraitsandtheir... Twenge and Campbell - 2008
*www-personal.umich.edu/.../Redman_Sept29_**TwengeCampbell2008**.pdf*

The modern workplace requires workers to have broad cognitive and affective skills. Often referred to as "21st century skills," these skills include being able to solve complex problems, to think critically about tasks, to effectively communicate with people from a variety of different cultures and using a variety of different techniques, to work in collaboration with others, to adapt to rapidly changing environments and conditions for performing tasks, to effectively manage one's work, and to acquire new skills and information on one's own (Koenig, 2011).

Work on a series of projects and you will never lack work to do or fail to get noticed. A colleague of mine did conflict mediation and today was one sought after personality in the country. Another one did Information Communication Technology for Health Researchers and was flying all over.

Volunteer as a guest editor or reviewer for a journal or better still starts one, volunteer to man a call centre, volunteer as an administrator to a professional website or blog. Or write like this author does, relating your observations to other issues linking them up and communicating them in your own style, it is only the publisher when he tells you it is time to do the typesetting that will stop you from adding further ideas into the manuscript.

Is a generation issue or something else?

… I also find some frightening issues with young nurses when I am in the hospital setting for either a loved one or myself. Twice within the last year, I observed young nurses breaking sterile technique with IV tubing with one nurse disconnecting IV tubing from the patient and "plugging" or looping the end of the tubing into an unsterile port on the tubing.

The second case involved the nurse dropping the IV line as she was ready to start the antibiotics onto the floor; the tubing was not capped and consequently, the sterile end of the tubing became contaminated when coming into contact with the floor. The nurse plugged the tubing into the patient's saline lock and began the antibiotic infusion without blinking an eye.

What happened to the mindfulness of maintaining sterile technique and the ethics of causing no harm to our patients? Do these nurses feel that antibiotics will take care of their breaks in sterile techniques? I wonder where all of the training and ethics went in these two situations. I wonder if it falls on deaf ears because the students do not see these issues on their Nursing Council exams. *(Shared by Anne P. online)*

One sure way is to start a reflective journal, keep a pen and notepad next to you, then look-write; listen-write; read-write; and write-write. These are just a few tips that this author is familiar with and there could be thousands more out there. These can be done on top of primary roles as nurses. There may not be any monetary value attached to most of them, but they spice up life and give you something to look forward to.

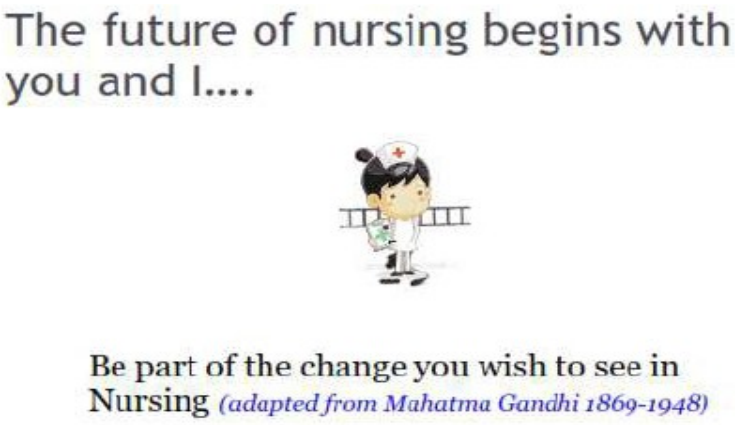
Even with this in mind, it is important to know that 80% of today's jobs are found through networking(recruitingblogs.com), career fairs and recruitment agents which potentially stimulate productive collaborations/increase awareness of positions. Through the online recruiter platform like Relode marketplace and referral platform one could leverage their professional network to become a parttime recruiter of healthcare jobs connecting colleagues to potential hiring institutions and earn some ‘agency’ fee in a professional way (www.relode.com/).

According to *NerdyNurse* Brittney Wilson, working from home on a side hustle basis as an independent nurse recruiter was a reality. Other possibilities included becoming a blogger, a nurse content writer, a home care nurse, a case manager, a nurse coder, a nurse researcher, a nurse advocate, an online nurse faculty etc. Locally, I may not be certain of or aware of similar

outfits above, nevertheless it is was good to borrow ideas from elsewhere go ahead: join them but even more important start some.

Organized volunteering bodies in Kenya similar to International Peace Corps would be a great avenue to explore. I would like to quote one volunteer 'www.MedicalMissions.org has been a valuable resource for us, I highly recommend *MedicalMissions.org* to any Medical professional who is seeking to serve on a Medical Mission', these was the testimonial by Dr. Paul Whisnant concerning medical volunteering. *"There are numerous physicians, nurses and other medical specialists who are in the healthcare industry to truly care for others. Let's help them help others."* Rick Jackson, Chairman, and CEO, Jackson Healthcare.

Therefore we will need to identify potential in everyone and see a treasure wherever our posting takes us, but first and foremost in our call for duty, we must not allow what we don't have to stop us from using what we have.



This chapter was not intended to further the interests of one group over any other. It was meant to frame (*as opposed to flame*) a debate - The future of nursing. It was not the intention of the author to further inflame the rhetoric (some divisive) that have been offered by some leaders of the health professions but rather to contribute to thoughtful solutions. This self-censorship is a prime message that users in a confession by one who this author felt deserved a *carelee* at large (see Box 1 below):

Box 1: 'Confessions of a Hospital Administrator'

'Confessions of a Hospital Administrator'

Posted by L.O on KNUN wall on Facebook on January 2nd, 2014

Gallup announced the results of its annual "Honesty & Ethics in Profession" recently. I was so pleased to see nurses ranked number one in the survey because they certainly deserve the honour. With the exception of grade school teachers, who ranked third, nurses were the embodiment of what it means to have a calling of dedication, grace, and love.

I worked in hospitals most of my career with much success (and a few times when I was not successful, but that's a story for another day). I started as a manager for what is called an "ancillary service", or nonclinical service. These include such areas as housekeeping, food services, engineering, IT and accounting. My specialty was public relations and marketing. I finished my career in hospitals 28 years later as a CEO responsible for an approximately $80 million in net revenue and payroll for up to 700 employees, mostly nurses. I even won a few awards, including being named nationally, with my executive team, as "Top Leadership Team in Healthcare for Mid-Sized Hospitals" by HealthLeaders magazine in 2009.

I was compensated well; on average about four times that of the average nurse's salary. Something I learned, as my career progressed, however, was that even with recognition and high compensation there were days I was barely worthy to serve nurses. The truth is I neither had the brains nor the courage to be a nurse. But I finally did figure out how I could serve as a useful hospital administrator to nurses as they went about the sacred task of laying hands on patients every day. Serving nurses is also a good way for an administrator to run a successful hospital.

Every metric on which hospitals are evaluated – from quality outcomes to safety to patient satisfaction to staffing efficiency to medical staff confidence – is dependent upon having a staff of nurses who feel valued on the job. It's also the right way to be in charge of a hospital. Here are four things a hospital CEO can do to serve nurses and manage a hospital well.

1 - GetOutofYourOffice

If a CEO ever wants to be anything more than the latest suit in the front office, go to where the work of the hospital is done – at the bedside. I learned this important leadership tip from one of my two mentors. It wasn't always easy and there were many a day when I didn't think I had time given the work and people lined up in my office. But without exception, once I made it to the floors to where nurses (as well as physicians and other therapists) worked I understood it was the most important part of my day. Invariably I would find inspiration that made me work happier when I did get back to my office. And when nurses see an administrator every day, they begin to open up. The administrator hears what they need to hear, not what staffs think the administrator wants to hear.

For example, one day while making rounds I noticed the nurses seemed aggravated. When I asked why I discovered that they were running up the stairwell to another floor to get ice for patients. The machine on their floor had been broken on and off for weeks. Do you know how much ice nurses use? When I got back to my office I called the Director of Engineering and he told me they kept fixing the machine, but it was old and needed to be replaced. When I asked why the machine was not replaced with a new one, the Director said he tried, but the Chief Financial Officer (CFO) told him that a new machine was not on the capital list. Now, this hospital was doing well and had discretionary capital money. And the CFO, in his mind, was doing his job by controlling expenses while the Director of engineering was focused on the matter of the equipment's readiness and not the effect its downtime was having on staff and patients. But if I had not been up on the floor every day I would have never noticed that something was amiss with the nurses.

Needless to say, a new ice machine was ordered and installed within a week. Not only was the action of the Engineering Director and CFO insensitive and a bit clueless about the work of nurses (which I addressed), but the frequent trip to the next floor to get ice was terrible for productivity and patient satisfaction.

Getting out of the office also includes coming in a few times a month to make the rounds to visit nurses on the third shift as well as on weekends and holidays.

2 – If You Want to Solve a Problem in A Hospital, Ask the NursesNurses are really smart – they have to be to get through nursing school. If an administrator comes up with a bad process to address a problem without asking nurses what they think, it won't work. Because nurses are the queens and kings of work around and they do not suffer fools gladly.

When we were having a persistent problem with falls and the magnetic door signs my Chief Nursing Officer and I had decided would fix the problem didn't, we finally put together a committee of nurses to figure things out. It didn't take long. Their solution included; nonslip socks; beds with built-in alarms for high-risk patients (and a built-in scale, which also reduced back injuries among nurses); more frequent bathroom visits for patients at high risk; and family and patient education. And guess what? Our fall rate decreased to a fraction of the national average.

3 – ProtectYourNurses

There is a lot of power and money in healthcare. When these two things get mixed in with human nature, the politics can be rude and nasty. In hospitals, nurses are often on the frontline of this dysfunction. I am a collaborative leader, but I have had to stand up to doctors who thought they could bully - and even sexually harass – nurses. This included forcing three physicians to resign from the medical staff or have their privileges involuntarily revoked. I have added armed guards in hospitals to protect third shift nurses from intruders and mentally ill, combative patients.

I have had to argue against corporate drones that wanted to reduce nursing staffing ratios per patient to levels lower than safe national averages. And while patient feedback is usually valid, there are times I've had to listen politely while an unreasonable family or patient member made unfair accusations against nurses of the most outrageous nature, often in an attempt to get their hospital bill waived.

It wasn't always easy or popular for me to take these positions. The medical staff doesn't like it when an administrator takes a stand against their colleagues. Patients and family members write letters to editors and post their venom on social media. Even my own senior managers have pushed back when I insisted they set a good example. But that is the job of an inspirational leader: to live the Mission, Vision, and Values of an organization all the time, not just when it is easy. And it is worth noting; an inspirational, servant leader still holds others accountable. The difference is staff has a say in the metrics, which fosters ownership.

4 – Remember –What Happens in a Hospital is Not About You

I heard Al Stubblefield, the founder of the most successful servant leadership hospital system in the world, Baptist HealthCare System in Pensacola, Florida, talk about his transformation from a command and control leader to an inspirational leader. "We used to come to work early and spend all day and eat two meals in the executive suites and then go home. And we thought that was a good day." There is a real temptation to think the endless meetings that administrators sit in are the business of the hospital. I once had a CFO joke to me: "John, I feel like we're an advertising agency that does healthcare", so I was not immune to this mindset. And certainly what a good leader contributes to a hospital is important.

But that's exactly what it is – a contribution, not the end all. I have seen first hand that even when hospital administrators are embroiled in whatever political fight of the week may be, patients still get taken care of day in and day out by the nurses on the floor. They are quite capable of doing so with a total lack of nonclinical leadership.

And finally, remember this; there is a reason administrators (business executive) ranked far down the list at 22 percent approval compared to nurses number one ranking at 82 percent: hospitals are a nurses' domain, not the CEO's. The fact is that we are all going to be a patient someday. Nurses will be the ones who comfort our fear, ease our pain and make us want to go on, not the CEO. But a hospital CEO can help care for patients by making hospitals a good place for nurses to work.

[Original article by John Mitchell, CEO Grays Harbor Community Hospital, US].

Acknowledge the role played by L.O who accessed it and posted these accolades when all else was not working our way as a nursing fraternity. Nominated by this book author the most heart lending post on KNUN wall 2014].[Available: allnurses.com/nurse.../confessions-hospital-administrator-895507.html]

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Chapter 18

The Role of Nursing Education in Quality Health Care in Resource-Constrained Settings



18.1 Introduction

I wish state that this chapter's insight was sharpened during my PhD Thesis in Medical Education at Moi University entitled: *BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis: A Primer Model for Kenya.* Negative impact on quality of nursing care could be related to anomalies in nursing education as well as poor structure of career progression is a fairly foregone conclusion. This was especially so in resource poor settings like Africa. In an ideal situation there would be need for perpetual learning in order for one to remain relevant, competitive or otherwise useful. The need for consulting empirical evidence was critical for the nursing profession to develop and command respect among equals in science as a caring professions.

Unfortunately promotions and deployment in public service had more to do with years of practice and less to do with advanced knowledge (once in a while both). Furthering nursing education was therefore more of a personal effort that did not conform to a laid down career progression structure. Stalling and stagnation did happen inspite of advancing knowledge.

The nurse workforce constituted the largest sector of health professionals in Kenya and included individuals with varying educational backgrounds and expertise. From Kenya Enrolled Nurse (KEN), Kenya Enrolled Community Nurse (KECN), Kenya Registered Community Nurse (KRCHN), Bachelor of Science of Nurse (BSN), Masters of Science of Nurse MSN, Doctor of Philosophy (Ph.D.) etc. Movement from one scope to the other advanced one depends on advancement of knowledge.

As the registered nursing population in the country shifts to becoming increasingly degree-prepared, unintended consequences (employment, earning power, skills, and roles and responsibilities) for those nurses who do not achieve higher education may occur. Like other health professions, nursing includes a large number of specialties and subspecialties.

18.2 Levels of entry

Policy makers and those in government simply get confused by all the cadres and levels of nurse training and see that as part of the nursing problem (Khoury *et al.,* 2011 *Gallup study*). At times nurses issues have been dismissed that way. An example was when AWW, a finalist BSN student petitioned the Eleventh Parliament (No. 01 of 2016) Second Session in conducting parliamentary initiative for enacting absorption of degree nurses.

Some legislators asked why degree nurses, why not all nurses or why not just say

nurses? Many were ready to use such excuses to evade real issues instead of drastic changes. This could be likened to putting Elastoplast to a wound and hope it will heal. Listening in, perhaps such ambiguity was what provided fodder for them to downplay the real issues, with *point of order Mr. Speaker Sir!*

Nurses must have lost numerous benefits just because these issues compounded or complicated their line of argument. An example was when there was a push to end enrolled nurse training, allowing the job category to dwindle as enrolled nurses retire over time. The then Minister of Health Hon. Charity Ngilu rejected the move. Shortage of staff to support various functions is a challenge if we are to base our argument on cadres.

By 2015 a number of MTC's admitted pre-training students for a certificate in Enrolled Community Nursing under the World Bank sponsorship - Beyond Zero Campaign initiative. In April 2017 admitted 400 students to KMTC's for KECHN.

KMTC scholarships were advertised in November 2017 targeting candidates from marginalised and vulnerable groups (VMGs) willing to serve their communities upon graduation under the program *Transforming Health Systems for Universal Coverage*.

According to HSA 2010 report by Luoma *et al.,* (2010), any given year finds well over nine thousand medical professionals in training in Kenya. How this impacts on the ratios of staff to patient has not been documented, but the Hivos study 2013 covered in chapter 2 did something on absenteeism, while I would expect the effect on direct patient care to be the same in both cases. In-service training in Kenya has largely been opportunity-driven, rather than based on the skill-acquisition needs of the sector or preference of individual providers, how this impacts on the quality of health care provision was not accessed by this author.

According to HSA report by Luoma *et al.,* (2010), there was increasing need to strengthen pre-service training at various levels, to align skills with the requirements of the health sector. With an unprecedented growth in professional knowledge, rapid changes in health care system, changes in the nurse's role and the emergence of new diseases, it is imperative for nurses to pursue higher academic qualification to develop specialized skills to better manage health care.

Encouraging and even requiring higher education for nurses had driven many nurses in Kenya to seek RN-BSN upgrading. It has also been observed that more universities are opening up space for upgrading Registered Nurses from Diploma to BSN in Kenya offering upgrading programs with flexible modes of study to cater for the working students. The Nursing Council has a list of accredited institutions offering this program[77].

In Kenya, there exist clear and well-disseminated standards and guidelines for clinical care, nursing qualifications, and licensure, as well as accreditation of training institutions. Every three years, nurses are recertified based on documented criteria such as continuing education credits. These regulations are well spelled out in the nurses' codes of conduct and ethics for the various nurses' professional associations.

Kenya is also likely to go the way of other countries like Lesotho which planned to raise annual graduation of nurses by 42%, Ethiopia planned to introduce a 'flooding and retention' strategy and accelerated training to increase the number of nurses (Mullan F. in Bangdiwala 2010). This would lead to a deliberate policy to export the nurses,

something we in Kenya should emulate as a matter of urgency.

Seemingly we have more than adequate capacity to train nurses but an underperforming capacity to absorb them mainly for economic reasons. That is assuming that we have not undermined their quality and capacity to compete in a global economy. Plan for a global market. As my economist friend used to put it 'you must think as the market thinks'.

There was an urgent need now more than ever to shun mediocrity. Collins Ogbolu in Lead Nurse Africa blog observed that in Africa career growth in nursing without intellectual growth was a breeding pill for mediocrity. Promotions ought to be fair and transparent manner, the overriding factors should be competitiveness, meritocracy and absence of nepotism, tribalism, cronyism and political influence.

It was hoped that the Draft PSC Regulations (Validation) 2018, set to replace the PSC Regulations of 2005, once approved would require public servants to not only sit for an exam but that other competitive and objective methods of recruitment and selection will be applied. Aptitude or other competency tests where appropriate. (PSC - Public Service Commission of Kenya).

18.3 Need for more educated nurses

Within the field of nursing there are opportunities to work in different specialty areas. "A more educated nursing workforce has the highest potential for achieving the best possible patient outcomes," said Burnes Bolton, who also served as vice chair of the IOM committee. Hospitals that had implemented policies to raise the education level of their nursing staffs cited quantitative successes.

There is also data suggesting that more educated nurses were more satisfied with their careers, one study from the local setting was able to document this with some certainty (Chebor, 2014).

The issue is not just about having access to care; it's making sure that when you have access to care, you're receiving the best, the safest, the most efficient, the most effective care," she said. "We need our nursing workforce to be highly educated to be able to deliver on that demand." Winter (2015) added, 'It is now, more than ever, a necessity to have a well-trained, highly competent nursing workforce. Simply having the knowledge and the skill to do a job is insufficient; rather, it is implied that a competency has an action attached to it that verifies what is achieved by that action.

According to the National Database of Nursing Quality Indicators, the nurses themselves reported better satisfaction in their work environment, their contribution to quality, their collaboration with physicians and the support they received from hospital leadership.

Compared with hospitals in which only 30% of nurses had bachelor's degrees with nurse workload care of an average of eight patients, mortality would be almost 30% lower for patients at hospitals in which 60% of nurses had bachelor's degrees and nurses care for an average of six patients (Aiken *et al*., 2014).

This was according to American Association of Critical Care Nurses (AACN) study that confirms the strong link between nursing education and patient outcomes. The study findings interpretations were that; Nurse staffing cuts to save money might adversely affect patient outcomes.

An increased emphasis on bachelor's education (see BSN as a basic below) for nurses

could reduce preventable hospital deaths. With such a prospect, then it is an insult to the nursing profession in Kenya that some counties in the year 2014/15 could *afford* to 'secretly' hire some BSN nurses on contract for a paltry Ksh15, 000 (equivalent of 145USD) per month.

These counties deployed them mainly to run the county hospital ambulance(s). Moreover, who said this was the best job for them? Considering they were mostly trained with inpatient and some community focus and much less on emergency nursing?

To the best of this author's knowledge, such an ambulance regular or permanent deployment is best left a nursing team with Advanced Trauma Life Support (ATLS), Advanced Cardiac Life support (ACLS) and Emergency Obstetric Care (EmOC) certification. In our resource-constrained setting, a team of well-trained paramedics/technicians can do (See **BSN as basic** below).

It's been said elsewhere but I will emphasize again that a window of opportunity exists to promote the one year higher diploma programsfor both registered nurses and BSNs for its utility value in terms of care delivery.

Yet we lack a concept paper that would outline whether or not the diploma will be referred to as post graduate (PG) diploma for the degree holders and Higher Diploma for holders of a basic diploma.

But again they will be in the same class, so? Or can a PG be granted only by a certain institution or does it become one when one had a previous degree? I recall with nostalgia that for a long time, only nurses got yet an (another) diploma at a post basic level. It seemed the titles of a Higher Diploma or Higher National Diploma was something they neither liked nor deserved.

Only nurses of all the other midlevel health care professionals being trained in Medical Training Colleges could not finish an ordinary diploma in three years but had to go an extra six months, a total of 3[1] 2 years. Why indeed?

BSN as a basic

Although a BSN education is not a panacea for all that is expected of nurses in the future, it does, relative to other educational pathways, introduce students to a wider range of competencies in such arenas as health policy and healthcare financing, community and public health, leadership, quality improvement, and systems thinking. – *Institute of Medicine* (IOM), The Future of Nursing: Focus onEducation

[77] RN to BScN through Distance Learning, Nursing Council of Kenya, Newsletter, Issue 6, Vo1, April 2010

Out there a Diploma is a diploma. Same job scale at entry level as those who finished in 3 years, that's ridiculous Some take a year, others two, even fewer take longer, it does not matter to many employers (even where an institution of higher learning is the employing authority).

Anecdotal evidence shows that some health sciences undergraduate programs and this could apply for many others have to go for long holidays in order to fit in a 4 years academic year calendar or rather they might be making up for a lack of content. One such a don admitted, 'we can crush this in 2 years!' This was as the undergraduate nursing program remained quite overloaded with no let-up in terms of time.

> *Guinness Book of World Records on 18th May 2011 rated BSN as the toughest undergraduate degree of all college degrees. In the 4 years (equivalent of 1000 working hours) with 64 university exams, 130 series exams, 174 assignments.*

In another way this was a good thing in the era of fake degrees although this does not indicate that there cannot be any cheating in a BSN program. Makerere University in September recalled 65 Bachelor of Law (LLB) degrees that had been acquire in the last 10 years (an equivalent of 5 graduation sets).

The authenticity was in line with the university policy. A press statement dated 21st September signed by the Academic Registrar confirmed the matter that had been making rounds in the media for some weeks. As expected this was going to brew a crisis for the legal profession.

The utility value of Higher Diploma and Post Graduate Diploma is not in dispute but they continue to be referred as horizontal education. Many employers have continued to get the most out of these specializations without commensurate emolument.

The nursing fraternity was caught flatfooted with less than an adequate number of specialized nurses in critical care and renal nursing when the government went for starting critical care units and dialysis centres in all the counties. Now it's for all systems go.

Results from a study *Innovations in Health Workforce Development for The 21st Century* by Kasina (2016) indicated serious disparities. Some of the 47 counties had as few as two (2) nurses and as high as forty four (44) nurses in others with critical care and renal nursing specialties.

There were six (6) training institutions offering these nursing specialization in the country. Whereas there was inadequate infrastructure in these training centres, some were handling a capacity of 25-30 students each.

The study was to establish existing workforce in nursing specialization and explore the efficiency of nursing development infrastructure. It came out that lack or inadequate workforce with knowledge and skills to handle the machines and manage the patients who needed the specialized care was slowing the effort to have two dialysis units in every county and ten intensive care units beds.

What about the nursing preparation with leadership and management of health systems. Many of our institutions continue to be run by nurses and doctors who have little or no idea on how to do it. Have we prepared for these positions coming up in the counties? The Health Bill, 2014 (got the president's assent in mid 2017) made some flimsy attempt

to rectify this. It has been covered in detail in Chapter 3.

18.4 Role of nursing faculty in assuring quality health care

According to the Institute of Medicine's (IOM) reported on the Future of Nursing (2011), graduate nurses will be the future leaders in practice, administration, education, and research.

IOM reported that due to healthcare reforms, multiple changes in the delivery of care and the number of Americans with access to this care, the need for highly educated nurses will expand dramatically. Accordingly, there is what has come to be referred to as Graduate-Level QSEN Competencies Quality and Safety Education in Nursing (QSEN) is a consortium for Association of American Colleges of Nursing.

The overall goal of the Quality and Safety Education for Nurses (QSEN) project is to meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work.

This author's opinion is that there is a disenchanted role of the nursing faculty in Kenya. The day our Kenyan graduate nursing programs will be taught by the nursing faculty will mark a major milestone in the quality of graduate nurses we get at the end of these programs and if they will be able to make a notable impact in their relevant areas.

The following situation is a fair representation of what could be happening. It was reported that there were situations where some institutions ran health related programs in undergraduate (and or post graduate) that no single member of teaching staff went through such a program themselves. Some of those interviewed admitted that they utilized the knowledge they received in their diploma and higher diploma. The rest of the staff by virtual of their 'relevant' graduate education gave inputs into these programs.

Many of our masters and Ph.D. nursing programs currently were generally taught by medical doctors and a lot of inputs continued to rely on non-nursing faculty, which put into question the content coverage. No less than the Cabinet Secretary (CS) of Education admitted that apparently, many Ph.D. supervisors were not well qualified themselves.

There were shortages in equipment and materials, poor compensation for researchers, the system lacked quality control and there was no clear mechanism for weeding out poor students. *One looks into how to survive in the program rather than finishing it*, as one recently Ph.D. grandaunt confessed.

It could be said that mostly our MSN (and entirely all PhDs) programs were research based with very little time on didactic coursework hours. Therefore, having fairly little in terms of content inputs that could be regarded as intriguing, critical stuff that engaged the students' minds on how to think. The kind of stuff needed to transform the landscape that was the Kenyan health system. The CS education and CUE impressed a new directive in ensuring that all graduate degrees had course content input.

The period from 2002 to 2018 could be said to have been lucrative for graduate nurses in Kenya up until CUE demanded that all public universities required to only have lecturers who at least have a Ph.D. degree by 2018. This was despite the Ph.D. degree enrolments for all programs being less than 10 percent of the total student population in the country.

The processing of students from the time of initial registration to graduation was too long. The majority of faculty members only had masters' degrees and therefore, technically did

not qualify to train post-graduate students.

New orders to get serious

But then, many students, world-over, simply paraphrase and lay claim to what has been stolen and the so-called plagiarism software cannot detect such sentences (*papaKenya* on social media, reacting to this news on The Standard). Paraphrasing and then citing your source in not plagiarism (*sufkim* added). There should be more. We need serious and capable scholars (*mts jumw* commented).

The best person to detect plagiarism is the supervisor and that is if s/he is well read (*musatsa5*). We having proposal writing joints and business in town - First work toward closing them as they are compromising quality of education… of projects even are done by …for a value (*mukiri*). That one is covered by the eleventh commandment: 'Thou shalt not be caught' (*mkenyamoja13*).

The University of Nairobi issued new regulations that in 2016/17 academic year a capping the number a supervisor could handle at a time to no more than 8 students (5 masters and 3 doctorates). It could only admit on a 'rolling on' basis. Prospective students were taken through lots of pre-matricualtion stuff and one was never sure of their admission status. Off course many gave up.

They also discontinued all Ph.D. by research by introducing mandatory coursework. Apart from introducing stringent anti-plagiarism guidelines for all research papers. As the only public university offering doctorate in nursing (only one other private one) in the country, this was going to present an uphill task in terms of access to graduate nursing education. For some time there had been a public debate on the quality of university education in Kenya.

For some time now the focus of our graduate nurse training apparently was to fill faculty positions. Most graduate programs had 3 students per class enrolling, and given at most 10 to 15 MSc Nurses graduate each in the whole country from all the five or so universities offering graduate programs, Kenya will continue to have a big shortage of these nurses in the coming years. They are ardently being sought for by the more than 21 institutions accredited by the Nursing Council of Kenya to offer undergraduate BSN programs.

Go-getter hiring institutions were booking them from the class before they graduate. Some are said to be willing to settle outstanding bonding terms from previous employers, primarily the hospitals. Many such are forced to re-advertise for positions or lower the 'irreducible' minimum requirements rubrics, if not give them appointments at a slightly higher entry level than would be usual with other disciplines. Purely nursing doctorates holders are fewer.

The problem in a big way lay in the remarkable cost of graduate nursing education and the numbing indebtedness of graduates. Nursing education at the graduate level apparently by some chance (or stroke of luck) is hardly regulated by the Nursing Council of Kenya but by the universities offering the degrees. This may or may not always be responsive to market demands for graduate nurses which are asking for innovative approaches including calls for increased interprofessional education.

Nurse Practitioners

NPs are trained at the graduate level and generally have a master's of nursing degree or a doctor of nursing practice degree, with a specialization in primary care, acute care or psychiatric/mental health nursing, sometimes with a focus on paediatrics, adult/gerontology or women's health. NPs must qualify as a registered nurse before they can complete a graduate-level nurse practitioner

program. Master's level training takes one to two years of full-time study and includes clinical rotations. Doctoral-trained NPs typically complete another year of postmaster's training and complete a higher level of clinical hours.

[Source: Research Brief No. 13, February 2013; National Institute for Health Care Reform Download Yee et al., 2013.pdf]

Would it be acceptable to come up with an innovative enterprising curriculum where students graduate in less time, cost and achieve the same outcomes as graduates from more traditional curriculums? Can't we be more innovative? Come up with tailor-made programs that serve our people, not our ego. Some accelerated graduate degree programs (15 months to 24 months) are needed in our systems.

It is about time we asked ourselves whether we get a favourable rate of return on investment for our graduate students in nursing when we charge them so much fees and make it so hard for them to graduate on time. Compare this (time wise) with starting a Masters through to completing a Doctorate of Nursing Practice (DNP) it can take a of 3 to 4 years in the US, coming back to Kenya as a Doctorate or Ph.D. if you like!

Funding for universities was becoming a real challenge. The Auditor General's report based on 2015 and again in 2018 indicated that 11 public universities were technically insolvent and could not meet their financial obligations. Delayed salaries was becoming a norm. A good number could hardly submit statutory deductions (pension, NHIF, PAYE, Bank loans, Saccos etc.). Many staff medical schemes were stale and hospitals had started turning away lecturers. Multi-billion shillings' projects had stalled. With effect from January 2018, the ministry was rolling out even more stringent measures curtailing on further expansion of campuses and employment of non-teaching staff on permanent and pensionable basis.

The processing of students from the time of initial registration to graduation was too long. The majority of faculty members only had a masters' degrees and therefore, technically did not qualify to train post-graduate students.

The next example on nurse educator opportunities had already been alluded to in the previous chapters, but from a different context, nevertheless there is a good reason to revisit it;

> As alluded to earlier the period from 2012 to 2017 was lucrative for graduate nurses in Kenya. Why? It seemed that for some time, the focus of our graduate nurse training apparently was to fill faculty positions. Unfortunately these were very few. Most graduate programs had 3 students per class enrolling, and given at most 10 to 15 MSc Nurses graduated each year in the whole country from the five or so universities offering graduate nursing programs.
>
> Kenya will continue to have a big shortage of these nurses in the coming years. If we consider that they were also needed as clinical nurse specialists etc. They were ardently being sought for by the more than 21 institutions accredited by the Nursing Council of Kenya to offer undergraduate BSN programs. Go-getter hiring institutions were booking them from the class before they graduate. Some were said to be willing to settle outstanding bonding terms from previous employers, primarily the hospitals.

Many universities were forced to re-advertise for positions or lower the minimum requirements rubrics (which obviously went against Commission of University Education - CUE directives), if not give them appointments at a slightly higher entry level than would be usual with other disciplines.

All the nursing faculty chairs wanted was: to fill vacant positions, reduce staff turnover, attract prospective students, push the students through the system (the university) by seeing to it that courses were taught, not having to defer them because of lack of teachers or part-timers, practicals were undertaken, exams/assessments administered and marks submitted on time.

The unwritten policy seemed was 'attract and retain partners'. Where possible snatch staff from competitors including where possible convincing promising external part-timers to leave their current employer. Programs had to meet some target of generating income for the university through the privately sponsored students and other income generating projects.

The private sponsored students program was expected to fund like ¾ of the budgetary arm of many institutions. Stringent measures by Kenya National Examination Council (KNEC) from 2016/2017 also made it difficult to have a sizeable number of students getting minimum C plus university entry criteria. Fortunately it was the same year that saw private universities been given a chance to admit government sponsored students program (GSSP).

All the students who scored C+ got a chance to be admitted under the GSSP. It was unfortunate that especially for health sciences programs the government did not send the commensurate capitation for these students which was generally above Ksh 220,000 per academic year. The students had to be turned away from the private universities or choose a different program there.

The question remained: was it CUE or professional bodies which should regulate professional degree courses in the universities. Right from 2011, turf wars between CUE (then, Commission for Higher Education - CHE) and these bodies have been witnessed, with courts pronouncing themselves one way or the other. Each had a quality assurance and accreditation mandate coupled with muscles to flex, weight to through around but most important 'teeth to bite'.

Regulatory bodies had suspended courses in some universities. Pitying the commission on one side versus 19 or so professional regulatory bodies. In February 2017 CUE was suspended from solely accrediting degree programs in an application filed by Kenya Medical Laboratory Technicians and Technology Board and Kenya Medical Practitioners & Dentists Board. By extension, what nursing faculty wanted or was struggling to achieve and what CUE wanted were two different sets of priorities.

The new CUE regulations decreed that a graduate studies supervisor shall not have more than 5 students (total masters and doctorate). For some time there was an ongoing public debate on the quality of university education in Kenya. Apparently, the lecturer job could no more let people in than it could keep them out. A number of universities had started laying off untenured tutorial fellows who could not meet the terms of the (2 years renewable once) contract within which to acquire a doctorate.

For a good number of those who went for further education especially the vertical mobility (RN-BSN. BSN-MSN, MSN-PhD) if you ask them why the answer they give is: *They want to teach*. Ever being in school for them is a Ka-lifestyle. How can we tap this urge to teach among our nurses in Kenya? Could it also mean that we have more nurses who are teachers and not nurses? May be.
For those who are called into teaching, they will teach even if it pays less (and it does) than

clinical work. But for a good number they have not done their homework, so they believe there is a lot of money in teaching, period. (Please see **The expertize nursing education doesn't have and the experts it has chosen to ignore** below).

Unfortunately, some do not realize that money in nursing is in clinical work, which anyway is more available and has more slots. If indeed one was to compare a Nursing Officer II (two) in a teaching hospital like Kenyatta National Hospital or Moi Referral earns an equivalent of an Assistant Lecturer Grade '11' or a Tutorial Fellow in a publicuniversity. One did not need to be a degree holder to be a Nursing Officer II, just 3 years working experience from Nursing Officer III.

Apparently a new graduate with a BSN (after internship) entered the system as a Nursing Officer I (One) in these two hospitals, essentially earning more than the Graduate Assistant, Tutorial Fellow, clinical instructor, a senior technician who used to teach him or her a year or so earlier. Yet it required a minimum of a Master's degree to be an Assistant Lecturer/Tutorial Fellow with proof of Ph.D. progression.

A Tutorial Fellow (TF) was actually appointed on contract basis grade '11'. It would make sense to assume that the few nurses with Master's degree working in clinical practice or elsewhere would be willing to join academia for a 2 year untenured (renewable once) contract as Tutorial Fellows, earn much less (if we factor in the new nurses' CBA of 2017 with the ministry of health and county governments).

Even fewer could be expected to be pursuing a doctorate degree. There was little incentive to continue into a lengthy Ph.D. program monetary wise. May be, as a result, some nurses considered pursuing a doctorate as generally "worthless" except for those already working in a university.

A good number of Ph.D. candidates never finished at all. The platform for doing research was not well-supported. There was a scarcity of funding for doctoral studies. So far the funding burden naturally fell on the students leading to high drop-out rates.

CUE required that universities allocate a minimum of 2% of their recurrent expenditure to research activities; this was inadequate considering it also depended on what it was that the 2% was of. The long way to the professorship and the relatively low income of dons in Kenya made pursuing a Ph.D. a less attractive option.

Notwithstanding this, from 2012, CUE guidelines prescribed doctorate as the minimum entry into 'academia proper' in lecturer grade '12', a very humbling earning substantially. Yet the health industry as it were required only a nursing diploma (higher diploma) or at best an undergraduate degree and were much more lucrative than the academic jobs that needed graduate education.

Many of the diploma nurses admitted to the university for RN_BSN upgrading programs would essentially be earning better perks than a good number of their lecturers in public universities. A general nurse in Kenya who could garner enough energy to do a few overtime locums per week can make plenty of money (about Ksh 200 - 500 per hour), possibly much more if the time were to be an equivalent to current Ksh 1350 per credit hour in terms of part-time lecturers.

It would be realistic to know that nursing faculty operates in a highly competitive market

where nurses with graduate degrees can receive much higher salaries from the hospitals and the rest of the health systems (Feldstein, 2011; pp327). A significant factor in the shortage of nurse faculty in the US then was that faculty salaries were lower than market wage.

In Kenya the high demand for upgrading RN-BSN (though dwindling in some catchment areas) and the regular BSN degree, for universities nursing schools to increase tuition levels they should be able to attract the necessary resources to expand their capacity and admit a greater number of students.

A nurse who is at the level of Assistant Chief Nursing Officer (ACNO) and above needed not think much of many a university dons in terms of money. If the collective bargaining agreement (CBA) by the nurses' union got through (and there has been a lot of labour unrest along this path) then the difference will be exponential. Some critics felt that it was apparent that 'while the rest of the sectors (in Kenya) had moved on in terms of remuneration dons had been left with just titles'.

Certain university interview panels had not come to terms with these dynamics. Some got amazed by previous earnings of many nurses transitioning from the clinical area. One such a promising candidate was desperately needed by one university due to the much needed specialty in maternal & neonatal nursing was offered the position of an assistant lecturer with an enhanced salary going to be equivalent of a serving lecturer. Unfortunately, she did not think the offer was good enough since another university was offering her a full lecturer position with better perks. The begging questions then were:

- For the same qualification, same experience the candidate would be hired at different positions by different public universities;
- How can the universities attract more nurses to become teachers from catchment areas like the main referral hospitals? Zero option if we consider nurses income to be higher than they would get in most universities.

The referral hospitals had the highest concentration of degree nurses. So much for that, hopefully, this puts the case to rest. The Nurses (Amendment) Act 2011 and the Health Bill 2015 (now Health Act), if they were to be implemented to the letter, would provide for seamless opportunities for the Kenyan nurses and other healthcare workers like no other time before.

The Directorate of Nursing having kicked off, it was a matter of when not if any more, that there would be no need for Kenyan nurses to out-migrate for a good number of nurses (though the working conditions locally were still unacceptable). Money was also not forthcoming although there was willingness on the part of the employer to pay. The country's economy had not been doing that well in the 2015-2018 period.

The Cabinet Secretary, National Treasury in 2016/2017 financial year budget might have started showing some recognition of this fact when he proposed that the budget did not provide for any salary increment and had suspended promotions in all sectors except for health care workers.

A handful of Doctorate of Nursing Practice (DNP's) holders were trickling back after getting the further education outside the country (See **Nurse Practitioners** above). As usual few were taking up clinical work as clinical nurse specialists much as this is where they might have made the greatest impact. This in effect might mean we have a long way

before direct patient care can feel their impact.

Apparently, for some strange reasons, most of the faculty in Kenya isolate themselves from clinical areas. One nursing faculty shared that *the day I no longer see myself in the wards will be the Day*. With this attitude, it is no wonder that there could be a lot of malcontents making up the faculty. It was a fact that not every nurse would like to work with patients but there are much needed desired characteristics of a thriving partnership between faculty and staff nurses that must be cultivated.

While this may vary from one institution to another but generally student nurses' preceptorship/mentorship had been found to be wanting in Kenya. May be it's the proverbial *'People who love their work and hate their jobs'*.

A good number *run away into teaching* as one veteran instructor puts it. In a good number of such cases, armed with minimal exposure to direct patient care after BSN internship, candidates go for the MSN and that becomes the last time they would have anything to do with patients, except of course during students' clinical assessment week which might happen once a semester. Do we have this calibre in nursing faculty? Certainly, the answer is a colossal YES!

Would it be farfetched to insinuate that for some elements the health care system sort of rejected them? In other words for a good number, a nursing job might have ended up not being about what they thought it would be about. But then why should misfits teach, lead in nursing, one might ask? If they harboured less than good attitudes about nursing going by what they did or said, shall we not have invested in the wrong teachers?

What if by some chance these attitudes percolate to the students (and they will usually do), then the quality of patient care in future might suffer. We are interrogating the quality of health care provision in resource constrained settings and the quality of education and practice in nursing and allied health care really matters a lot.

Some nurse teachers however do not see patients as a necessary evil and value working with them, like this one who said 'I love direct patient care as I feel it's vital to stay 'in touch' at the bedside to be an effective healthcare leader and teacher'. Another one wrote 'I find myself pursuing an advanced nursing degree so that I may pass on to inspiring nurses the knowledge, caring, and compassion the Neonatal Intensive Care Unit (NICU) nurses demonstrated to my son and family in our moment of need'.

Many publications in the field of medical education show that health professionals fail and falter mainly in the area of clinical skills and communication skills competence. The "gaps" applied to nursing include:

- Theory and practice gap - students reported teacher during skill lab was not helpful and effective;
- Teaching and service gap;
- Academic and service gap;
- Academic and clinical gap.
- Unstructured clinical teaching perhaps contributed towards less skilled, not competent and not confident graduates

The focus today thus should be in addressing the gap between academic and clinical education and training. Irrespective of the program one was pursuing it might be

considered reckless today not to have a business mind and a sense of purpose but above all being responsive to market demands.

'Universities should be producing what the sectors that create wealth need…,' recommends Prof Dr Maggie Kigozi, a Ugandan medical doctor, consultant, business icon, educator in an interview with *The Scoop* (Africa 24 Media, 17th July 2017) (See **A collaborative forum for trainers and clinicians** below).

Initially, nursing schools were part of the hospital with training being clinically based and task-oriented but today nursing education is in colleges and universities with so much simulation and competency based training. Outcome indicators of nursing education should include critical thinking, professionalism, leadership, embrace openness, integrity, broad based consultation and consensus building in decision making, innovativeness, and communication among others.

Most complaints by patients and by other consumers of health and health related services were about the practitioner's clinical competence and communication skills. To be more precise: they lack those skills. Those were the comments made by Dr. Marianne Darwinkel, VVOB (Flemish Development Association) project advisor while describing the skills lab methodology (Darwinkel, 2007).

Inadequate skills lab space and equipment contributes to students practicing on real patients resulting in increased patient's risk for medical and nursing errors, undue stress and dissatisfaction on patients. Given the risks inherent in learning new skills or advancing underdeveloped skills on actual patients, there was a need to explore innovative teaching methods for improving acquisition of competencies by learners.

Simulation is one of the innovative learning and teaching approaches in improving mastery of skills. It is highly interactive, allows multiple learning objectives in a realistic simulated environment whilst mirroring the clinical setting. Simulation improves patient safety and helps learners achieve competence while linking their theoretical knowledge with clinical practice. It enhanced patient's safety and quality of care as it contributed to safe and competent practitioners.

Simulation enables learning in a non-threatening environment, where they can make mistakes without endangering lives. There was a need to procure appropriate and cost-effective manikins, introduce new methods of students' assessments together with appreciation training on simulations for teaching staff.

Some universities were known to engage clinical instructors on the part-time (? voluntary) basis, mainly these were newly graduated BSNs post internship, every other one of them soon takes off once they secure better offers. Few ever get to see their appointment letters, (or could it be that they did not stay long enough?) as clinical instructors, even fewer got paid for it, and if they got the money it was after a long wait (a year or so).

The role of clinical nurse educator (CNE) has yet to be appreciated in many teaching hospitals in Kenya except Aga Khan University Hospital and Moi Teaching & Referral Hospital. Moi University, School of Nursing in collaboration with some visiting nurse faculty started engaging 'Clinical Nurse Educators' since 2013.

These are nurses already working at Moi Teaching & Referral Hospital. The initial terms were basically voluntary but ongoing negotiations might bring forth fruits in terms of commensurate pay. The impact these efforts have had are yet to be evaluated.

There were about 15 CNE's by mid-2015. There were about 8 institutions that sent their students to that sent their students for attachment to MTRH. One CNE confessed that there were 450 students from nursing alone in the hospital at any given time.

A collaborative forum for trainers and clinicians

It pains me that not even one tutor comes around to check on the welfare of the students in the clinical areas. No tutor comes to interrogate the nurse manager on how the students are doing. It demotivates the nurses to see that tutors are nowhere in the clinical area. We are a worried lot, are these the kind of nurses who are going to nurse us? We even don't know how much they know. If you are not seeing the instructor around whom are you going to believe -The student? The tutors miscommunicated through the students and not tutor-to-nurse, once in a while the student comes with a note from the tutor.

Signatures will not do, we remember that they are easy to forge up and not always possible to verify, what we need is student supervision. When nurses start to see students as colleagues and not as students it is not good for the students' learning.

It is good to make students busy, accountable for the time they are in the clinical area. Students spent a lot of time while in the wards on their phones doing stuff: chats and browsing… Nowadays students are monitoring vital signs using their cell phones instead of a second-hand watch, who is to blame. There ought to be a barometric clocking in/out system for the student. Bring out a nurse in the physique and psych of the student by empowering them.

At times students are given assignments which are beyond their capability. Some procedures have been abdicated by primary nurses to the students. Boredom, routine tasks act as demotivators to students. In some wards, vital signs monitoring was exclusively student's work even if it meant doing temperatures with only one thermometer for the whole ward.

It's the morning of the assessment and a tutor who has never been seen to come around to supervise the student appears and demands a co-assessor (ward nurse). You start running up and down looking for this and that on the material day. Most tutors do not adequately prepare the students for assessment. Sometimes there are overwraps of assessments from different institutions.

We are not working in a vacuum; we are working amidst other professions. As the nurse manager for my division, I sit in the interns vetting committee that conducts midterm and the final assessment on medical officers' interns. We assess how safe that Dr is to handle patients, everything from motor skills to availability to attitude. Even primary nurses have a say as to which intern can be released or needs more time to do the rotation. Why can't this happen for the nursing profession? Why must a nursing student transit from one rotation to another… to finish?

This was what some of our corroborative colleagues had observed about nursing in Kenya. That before introducing BSN, MSN, and Ph.D. that nursing care was better. The question is, what difference has it brought to the quality of nursing care in Kenya? May be maybe not, but suppose they were right? (As shared by participants in one collaborative forum).

The CNE role included:

Bridging the art and the science of nursing; bridging the gap between theory and practice, reducing medical errors; empowering the primary nurse to remove the tendency to relying on ungrounded opinions as a basis for decision making; doing a skills check, mentoring & preceptorship; supporting the nurse managers and nurse in charges;

Helping in doing root cause analysis; ensuring clinical supervision of students to help them meet their objectives by bringing up the students at their level of training; reducing conflicts between what is expected by the teachers and the hospital, conducting clinical nursing rounds and bedside teaching, handling the exchange programs students and fellows.

Small group clinical teaching increases both knowledge and attitude without significantly compromising other routine nursing care in the ward. The focus of ward nurses was mainly to finish their clinical assignment and but also supervise learning. This was becoming less and less a reality as the number of students to instructor or nurse ratios increase in our hospitals.

Caring relationships between faculty and students' generate caring moments. This author was a co-investigator in an international study carried out between February and August 2014 targeting 2nd year to 4th year students (McEnroe-Petitte *et al.,* 2016) which aimed to identify the level of students' and instructors' caring behaviours and if there was a correlation between instructors' and students' caring behaviours.

Respondents consisted of nursing students from identified schools and colleges of nursing in seven different countries, Kenya included. One of the data collection instrument is based on Jean Watson's (2010) *Theory of Interpersonal Caring* and was designed to measure nursing students' perceptions of instructor caring.

Some of the key areas included:

"Helps to Decrease Patient's Pain"

"Helps me to envision myself as a professional nurse"

"Demonstrates Professional Knowledge and Skills"

"Allows Patient to Express Feelings about his or her Disease and Treatment"

"Shows genuine interest in patients and their care"

"Cares about me as a person" etc.

Some of the reported findings were that instructor's caring behaviour affected nursing students' caring behaviour. Through positive faculty modeling and role modeling, nursing students could be professionally trained to develop the competence of caring. Moreover, when the climate of nursing education was perceived as caring, the student acquired a professional way of being and learned to care as a professional nurse.

If the instructor showed genuine interest in patients and their care, made the student feel that he/she could be successful, was attentive to the student when they communicated and allowed the patient to express feelings about his or her disease and treatment ($p < 0, 05$). If the instructor made the student to envision himself/herself as a professional nurse and inspired him/her to continue their knowledge and skill development, the student demonstrated professional knowledge and skills ($p < 0.05$).

The study has since been presented at several international conferences including *43rd Biennial Convention Conference Host: Sigma Theta Tau International, the Honor Society of Nursing. Las Vegas, Nevada,* USA. Added to Virginia Hendersen International Nursing e-repository http://hdl.handle.net/10755/603121.

For resource constrained settings like Kenya, it is a luxury we cannot afford to have a separation of faculty and nursing practice like it happens. Just like in the medicine program where doctors who teach in Kenya are on top of things in the hospitals and have vibrant practices, there is no reason why nurse educators should be allowed to shun practice to that extreme. The fact that it does happen in other similar fields' means it is possible for nursing too.

We need a model that would see practicing nurses who are qualified to teach seconded to teach while on the other hand those already teaching take up compulsory paid hands-on shifts in the hospital working alongside other nurses (with or without their students). The later suggestion would be a bigger challenge compared to the former, mainly because the nursing faculty would like everyone to believe they are fully engaged elsewhere and have so much in their hands, this is not necessarily true.

It would make much sense when a nurse educator or one in practice and now teaching is able to relate with what they are teaching to the students. With the fast changing scenario in the medical, nursing knowledge and evidence-based practice being the in thing this would really help (See **The ideal** below).

The ideal

One student from a private institution said, *'I would not like to be assessed here, although we do our clinicals here, we sometimes we borrow packs from another nursing home during assessments. It is not ideal. This is not what we were taught. We are taught to support the perineum well, it must not tear, but here things are different'.*

Having a complete delivery pack in many labour wards is something akin to a miracle, drapes were a nonentity. Some weird practices continue to exist (I can bet a few coins maybe even as you read this they still do) where delivery in low-resource facilities could be conducted using: a surgical blade instead of a pair of episiotomy scissors, 2 to 3 cord clamps, gauze, 1 or 2 pads if you are lucky, some cotton wool and some gloves wrappings and you are good to go. Never mind if there was no needle-holding forceps, one could always stitch an episiotomy freehand.

These comments are indefensible if they happen to be facts but they point to some real gaps between theory and practice as a minimum.

We cannot afford to behave like the developed countries since we lack in so many learning materials but we have the patient and that is the most important resource, let our student at least be very exceptionally good in hands on even if they would likely have one or two deficiencies in some areas.

Everywhere the Kenyan nurse has outmigrated to worldwide they had come out exceptional in terms of diligence, we can only step up this. On the few occasions when it happened and these were rare and far between when we were students we still remember reassuring words like in **Hands on** below.

With the interest of the patient at heart and for the sake of quality undergraduate nursing education the regulatory body should move in quickly to ensure that these standards are met for Kenya. It is likely to have a far-reaching impact on imparting the right knowledge, attitudes, and skills to the next generation. This would ensure quality provision of health care.

In their paper entitled '*Fundamentally updating fundamentals*,' two renowned nurse educationists Armstrong & Barton (2013) argued that quality (and patient safety for that matter) is no longer an elective content area in nurse education basic training. However, many curricula in Kenya are yet to include this concept.

To appreciate the challenges of offering quality care working in diverse settings, students undertaking health discipline courses are exposed to some of these rural settings as undergraduates through Community Based Education & Service (COBES).

COBES is a program of Moi University undertaken by all undergraduate disciplines in College of Health Sciences. Maseno University and the University of Kabianga also run a

modification of such a program using modalities that encourage active learning in the context in which students will later function as health professionals. (See Appendix VII).

18.5 The expertize nursing education doesn't have and the experts it has chosen to ignore

Even as nursing education in Kenya continues to face glaring shortages of nurse educators, a rising demand for degree nurses and the threat of some institutions being closed by the regulatory bodies for non-compliance; nursing educators chose to ignore something rather obvious.

The universities offering undergraduate courses in nursing continued to ignore a critical mass of qualified nurses who have come up through the system from diploma to higher diploma(s) to a basic degree with many years of experience.

These were people who had trained at great length and expense. To maximize the potential value of their additional education, nurses (or other professionals for that matter) should be encouraged to pursue graduate degrees early in their careers.

Nevertheless, this critical mass being referred to here were what had come to be referred to as 'career students' but then better them than those who 'graduated forever ago'. A scholar must continuously experience growth and self-discovery.

For a good number of them, they might never

> ***Hands on*** *'When you come to my ward I will show you…., infact right now we have a patient with…, remind me to show you…, this is how we do it here…. The books might say that but….when you come I will show you…..*
>
> *Let's go and I will show you… we have an interesting… You might not have reached there yet but this is a rare one you must see… Even if you are in another rotation please make a point to pass by my ward…This is what I expect you to do when you come to my ward…*

get a chance to take full advantage of their qualifications; for one academia doesn't want them (not that they don't need them). It was quite possible that many of them would be a ready and willing critical group that the universities could engage.

It was just hard to find a match for them even among masters' holders unless the latter practice what they have mastered – excellent; otherwise this could be regarded as a fair observation. While referring to this category of nurses it is a different story when we talk about lifelong learning. In fact, lifelong learning should be made a priority so that nurses are prepared to work in evolving health care environments.

Even amidst glaring faculty shortages, most Kenyan universities had chosen look down on professional qualifications below an undergraduate degree. This was not going to add value when it came to practical science programs like nursing, computing or engineering for that matter. In the perspective of a career degree like BSN this was committing a serious omission or to say it in another way it is academic ignorance.

Implementing an undergraduate BSN curriculum would least likely offer any meaningful challenge to this group of nurses. The most that had been offered to this group were adjunct faculty jobs or menial jobs within the undergraduate programs. Even when they did get an MSN their other qualifications were disregarded.

It seemed to this author that a Higher National Diploma and years of service were inferior in some instances to a single article in an open access journal whose singular merit was the ability to pay an author processing fee.

Commission for University Education (CUE) guidelines effected from July 2014 were not cognizant of historical trends in nursing education or the independence of each university to be run under the university senate. The clinical nursing had become a better option and was giving the nursing education a run for their money. The standard of nursing education would likely continue to suffer if we did not work towards identifying the weaknesses of these CUE guidelines and seek for some form of waiver.

Perhaps CUE was pushing the university reforms too far! Prof Lukoye Atwoli, then Dean School of Medicine, Moi University expressed in his posting on his Facebook wall on 18th August 2017. The posting attracted thousands of likes, reactions and comments from subscribers.

But then, this was also the era of indigenization *watu wetu kwa vyuo vilivyo kwetu* Swahili for local/our man syndrome for indegenization of the vice chancellor's (VC) position to be reserved for locals. According to Prof. David Some, formerly VC Moi University and CUE boss this was against the spirit of Univerities' Act 2012 Article 38 which set out merit as the main considerations for any such apointment.

If indeed universities should be at liberty to incubate their students the best way each of them knew how. He felt that interference by CUE towards ‘standardization’ of university education in Kenya was inhibiting creativity, innovativeness in terms of research and scholarly pursuits. Universities were supposed to be centres of excellence.

Nursing faculty positions advertised in the press might not have been worthy enough going by the paltry number of applicants who responded. There would be a few bold ones while only a few applicants qualify.

Even trying to reach out to the nursing fraternity through other means (e.g. on social media walls) to apply did not always yield much either. By the time the interviews season were over the few candidates with MSN had gone to each and every interview in the last couple of months.

In other words, all the universities had been cycling between or else interviewing the very same candidates. The candidates then had the last laugh as they go for the highest suitor. For the losers' it had been a waste of time, effort, and money. For some universities especially those in the rural parts of Kenya, they have to resort to depending on part-time lecturers for specialized courses and basic sciences.

Anecdotal evidence showed that many more students wanted to pursue nursing degree especially now that they were able to choose their career after the Form 4 results unlike when they did it before the exams. Nursing had become attractive for many reasons to students.

For example after graduating (and candle lighting) only a few months earlier, BSN graduates in their one-year internship were making good money in job group 'K' under the Ministry of Health sponsored program. These earnings were equivalent to (but usually) more than graduate assistants, senior technicians and clinical instructors who had taught them in some if not most universities.

The Nursing Council of Kenya, the statutory body in charge of regulating nursing practice and education continued to accredit many more universities for undergraduate BSc Nursing which was a good thing although in some instances *tutoring started without tutors*.

Another issue, a belated concern though, some institutions functioned with very meagre infrastructure, continued to have cohorts of students graduating from them year in year out yet they did without the necessary infrastructure like basic sciences labs.

It was alleged that in a certain (unnamed) county referral hospital, (not a very big one for that matter) had up to 3 universities and 2 MTCs clamouring to have it as their teaching hospital. They were all accredited. Officials from statutory bodies came to this same hospital despite having been there a month earlier and 'inspected' it all over again each time, but the difference was the same, *one could easily read it all over their faces...*

There was need for introspection into some of the motives (one perhaps being the accreditation fee) behind such irrelevant activities. The regulatory bodies' education & standards committee fidelity towards the profession as guided by the law and other sacrosanct policy documents must be beyond reproach.

Despite the lofty ideals of universities, they were not doing any better on the above issue. Instead of appropriating knowledge that they created in the university (e.g. exploiting intellectual property patents) they were competing to open more campuses all over the country. The unexpected was a convergence in this horizontal competition at some point.

Directors of these campuses had their work cut out for them –to generate income. Module II programs by virtue of profiteering were given prominence at the expense of regular ones. These campuses failed to get as many students as planned or had no lecturers to teach. This will be seen below. Nonetheless, in April 2017 the Cabinet Secretary for Education required universities to wind up some campuses and suspended opening of more campuses. Certainly there was a grip of quality crisis. Many such campuses did not have basic facilities like a library, lab, internet access and had a handful of staff.

The staffing shortage phenomenon in the nursing education defied the kind of panacea that Commission for University Education (CUE) had prescribed for higher education in Kenya. Anecdotal evidence showed that larger usually older universities infrequently used bureaucratic application processes, they even placed a caption on requirements for candidates in special fields concerning doctoral status (ongoing or completed), rarely asked for several copies of the application, some did not have advert reference numbers.

One particular one advertised for all teaching positions in health sciences discipline as one flowing paragraph with only commas between medicine, nursing, public health. Generally, they took a shorter time to shortlist and call for interviews.

Some other big universities were known to be *recruiting all the time* with summarized lists of potential candidates ever being processed by concerned departments. One, in particular, was known to constitute impromptu panels to interview 'endorse' one candidate.

This process was inexpensive but perhaps not competitive, it was prone to abuse. As such they rarely advertised and if they ever did, it was either they were desperate or to meet some policy regulations/constitutional requirement, in other words, *a formality*. They were more likely to employ someone with a higher grade, and even when this was not the case their offers for a start were favourable.

On the other hand, it was observed that smaller, usually newer universities appeared to be trying their best to implement the CUE guidelines. They tended to use a lot of bureaucracy in their adverts, complete with reference numbers to quote. They required ten copies of the application, needed referees to send recommendation letters by certain dates. It was observed that they took the shortlisting process more seriously, perhaps taking longer to arrive at the candidates to call for an interview.

They were mostly located in the less urban areas. Were more likely to employ someone with a lower qualification in order to break even, and even when this was not the case their offers were less favourable. For example offer a candidate the position of Tutorial Fellow who, with the same qualification gets a Lecturer position elsewhere (usually in larger universities). With all these factors they were more likely going to lose out altogether in the process with programs like nursing sciences taking large tolls. This is an area ripe for research.

Competition between universities and institutions based on the state of facilities and remunerations remains both a threat and challenge which may lead to loss of core staff. Some of those teaching staff already inside some of the universities would be applying either to get out or for positions higher up within. Something even more critical was that it was typical in many Kenyan universities for teaching staff to leave their previous positions in their university in order to get promoted to a higher one elsewhere.

Some staff had shared that it was difficult to get incremental credit after acquiring higher education let alone promotion internally in many local universities. This affected the staffing in health sciences a great deal even though medical courses remained high in terms of demand.

The problem was that some CEOs would not buy to that line of argument. Taking cognizance of the fact that the country's economy had not been very vibrant, as reflected in the rate of unemployment and the consequent careful selection of degree programs by students. Kenya, at 40%, had the highest rate of unemployment in the region United Nations Development Programme's Human Development Index report (2016). Approximately 200,000 students graduated per year.

A typical scenario was that between June 2016 and D e c e mber 2018 the following institutions advertised for almost similar teaching positions in nursing sciences: Maasai Mara University (MMU), University of Kabianga (UoK), Kenyatta University (KU), South Eastern Kenya University (SEKU), Great Lakes University of Kenya (GLUK), Kisii University, Maseno University, Masinde Muliro University of Science & Technology (MMUST), ZITECH University,

Meru University of Science & Technology (MUST), Kabarak University, Kenya Medical Training College, Kibabii University (KIBU), University of Embu (UoEM), Moi University. A good number of them for whatever reasons re-advertised a number of times

in that period. Consider the following **short answer questions** below that touched on the nursing faculty at different times.

Inside information had it that one of them had advertised for teaching positions in nursing and other 2 programs received less than 10 applicants (all the 3 programs combined). Competition from other universities and institutions with better facilities and remunerations was both a threat and challenge which may have lead to loss of core staff.

One university had requested candidates to apply for RN-BSN in their adverts and flyers brochures but after that, the applicants were put on hold, some for more than 5 years due to human resource-related constraints. Meanwhile, some of these aspiring RN-BSNs went elsewhere.

Short Answer Question 1

AX left *Zendi University* for *Kijani* on promotion from Assistant Lecturer Grade '11' to a Lecturer grade '12'. He felt he was overdue or was being bypassed for promotion by his former employer. *QP* was hired as an Assistant Lecturer at *Zendi* in the immediate follow-up period after *AX* left. QP however appointed on a starting salary at 91K which was higher compared to what *AX* began with at 84K *Kijani*. (Explain these from a human resources perspective).

Short Answer Question 2

Butis worked for *Zendi University* as an Assistant Lecturer, but for the same qualification, *Desktop* was poaching her to become a Lecturer. *Butis* was more at home at *Zendi University* but it was becoming difficult to move up, so she left. *Zendi University* was at a loss because this was the third time in 3 years that they were losing a faculty member to *Desktop* under similar circumstances. Infact they had similarly lost another one to *CPU University* 2 years earlier. But then they were citing CUE guidelines. They could not comprehend how *Desktop* and *CPU* were able to flaunt the rules, may be a question of values. Indeed it was said that none of the nursing faculty at *Desktop* or *CPU* had been appointed at less than Lecturer. Sources from an UASU official on national radio (during the academic staff union strike on 7th March 2018 *Citizen Radio* 'Good Morning Kenya') indicated that it had become common knowldge in some public universities that a Graduate Assistant (GA) -the lowest grade in teaching staff that depending on who, the GA could earn as much as an Associate Professor. (Explain the disparities) **.

Long Answer Question 1

A narrow window of opportunity did happen quite rarely but it did. A time during which the strict requirements by CUE were somehow relaxed (that for one to be a lecturer one must have a PhD). This especially happened in late 2017, some universities went ahead to advertise in the media putting a caption candidates must be registrable for PhD, or must be on data collection stage of their PhD. A few universities like Moi and Egerton went ahead and did internal

advertisements for their staff who were tutorial fellows, graduate assistants and assistant lecturers to apply for reviews.

This was not the case in others, it was reported that some treated it as an opportunity to pick and promote their cronies, the reviews being done within two to three days after the concerned was notified in what had become a fairly secretive business. (Discuss recent trends in reforms by the Ministry of Education)

Long Answer Question 2

In 2017-18, while private universities lowered their cut off points for health sciences programs, public universities remained stuck (*and with their too often strikes*) more students got admitted into private universities. Some public universities did not even get a single applicant into some of their programs.

***[While the situations were real, fictional titles and names were used. In all these cases the candidates held fairly similar qualifications at MSc level.* K was a short code for Kenya shillings (Ksh) as used in conversations meant the same thing*]* [script shared covertly by some dons]

Desperate times in nursing sciences were not unusual when staffing ratios were at critical levels. During such, Chairs of departments had been known to personally search everywhere for those with the qualifications.

The season could get frantic: phones, forwarded emails and Short Messages (SMS) were rife with *'are you interested, have you applied? Umesikieko (colloquial Swahili for - have you heard)? Have you read? Let me nikuzambazieko (conversational Swahili for - can I forward to you)?'* All these while it seemed some Universities' CEOs and human resource departments, education regulators and statutory bodies had not woken up to the reality.

Many universities lacked the doctorate, Ph.D. faculty to teach and supervise the students. Some especially those that relied on external partners to run the MSN programs had stalled, restarted or perhaps received few interested students applicants. '*Great universities worldwide are known for a reputable component of postgraduate (Masters, Doctorate, and Ph.D.) programs'.*

Prof. Jacob Kaimenyi (formerly Kenya's Cabinet Secretary for Education). But only a few of the 72 universities in Kenya (except may be Masinde Muliro University of Science & Technology - MMUST) seemed to be aggressively responding in terms of offering diverse postgraduate nursing programs. Few were able to start a stand-alone school of nursing and midwifery. For the few who try some had ended up with, some one or two-staff run departments or one with several thematics merged.

One veteran non-teaching staff commented on one university draining another. When the former principal of a university college left he left with literally all the former grade '10's from his former employer. In the new place, he prevailed upon them to advertise for grade '11's. '*You know these were the ones who run universities, they do the donkey work. Most had stagnated in lower grade despite having necessary qualification to move up'.* Imagine all the senior technicians and clinical instructors one could fish in nursing sciences just by giving them a grade higher.

A lot of nurses could be waiting in the wings to take off into academia but not sufficiently attracted by the offers the universities were giving. However, might consider a grade '11'. These mainly consisted of those either pursuing Masters or planning to do so. These tended to be quite productive; they formed a critical mass that would likely stay put with an employer for as long as it took them to break the *glass ceiling*.

Anecdotal evidence showed that 2-3 years was on average that most time middle-level nursing faculty (grade '11's and above) stayed with a single employer. But then wasn't it more lucrative to join the university sick bay as a nurse? There one could progress faster

than in the academia. A senior nursing officer in the student's clinic was at grade '12', but was not required to have the equivalent of their counterpart in teaching.

Apparently, some university CEOs in Kenya concentrated on infrastructure with a passion and sort of neglected human resources needs. In one such distinguished university, the health sciences had amazing everything else but very few teaching staff to the student population. The number was not even a bare minimum.

Lecturers were forced to take on many extra courses on part-time after full load and also to teach courses they themselves barely passed as undergraduates *if you ever did it at some point it does not mean you can teach it!* This is hardly an explanation some universities' management are willing to listen to. The days that courses were taught by specialists are vanishing very fast (see **External part-timers** below).

I might not be forgiven for thinking so but I feel that nursing education to degree and postgraduate without the adequate/adequately-prepared nurse educators (and therefore students) does NOT help quality health care and patient outcomes for that matter in this country. Are we kind of mismanaging nursing education right, left and centre?

What can we learn from the past? For example, several BSN programs were started by nurses who had advanced diplomas (and a Master's degree). This original lot still exists in some of the Medical Training Colleges and Universities, though to remain relevant in the university some have had to do a Ph.D.

There is a new crop of nurses who have gone through the mature entrance BSN or RN_BSN upgrading. For some of these, a Master's degree becomes a necessity for recognition otherwise how much else can one explain a nurse who had a 3 and 1/2 year diploma, a 1 year higher diploma (some had two or three higher diplomas or an advanced diploma) and now a Bachelor's degree? What some cynical faculty call …*lots of horizontal mobility with little or no vertical mobility*.

If we take it that this nurse has been working and specializing in midwifery and neonatal nursing or renal and critical care nursing then getting a master in maternal and neonatal or critical care nursing respectively becomes a formality. Does the nursing component in the education system for these cohorts need to be relooked? *'Eti nursing ni ile'* paraphrased from Kiswahili to say teaching the same nursing the same old way and expecting better results (nurses) just will not do.

Having the perfect plan to do the *wrong thing* takes us nowhere. It seems sometimes that many problems are solved just by planning, even if it is not the only area we need to improve. Many upgrading nursing students know the pain they suffered inflicted especially by some faculty who seem less knowledgeable compared to the students. How do we add real value not just a better paper to them? How can we spice up these programs for them so that they are not just repetitious of what they previously learned? How do we ensure they get out better, changed to give better care?

Nevertheless, it had been shown that these RN-BSN were the backbone of many teaching hospitals and that undergraduate students learnt a lot from them. Training must be related to industrial practice, and this was what these lot had more than the average BSN. They possessed many transferable skills that could land them a job in many areas of the healthcare industry apart from teaching.

For unknown reasons perhaps founded on suspicion, this group had not been allowed to shine by the said nursing faculty. Occasionally, they would be allowed to handle clinical assessments or clinical instructions (usually on a voluntary basis). A quick inquiry from among the BSN students' fraternity showed that they were good if not better, apart from being quite relevant; summed up in one sentence by one student *...they knew what they were saying and doing* (see **hands on** above).

External part-timers

One (sought after specialty) part-time lecturer in health sciences recounted If I calculate how much I will be losing by coming there to teach instead of how much I will make, distance notwithstanding, I would have no reason to come.

Some of the things they (part-timers) are capable of being outrageous. For example, one could teach all the 3 units of a course in a day then drive another university 200km away to teach the following day. Then let's say hop from Kitale to Eldoret teach there too the next day, get a plane to Nairobi teach some more, then off to Kisumu for an evening lecture.

We have not seen anything yet! Another part-timer who worked in some West African country said 'Kenyans were like the clock, very fast upstairs but stationary at the same time because they have not invested in the fast train and the local air travels. Local air travels are so expensive I wonder why. Systems do not work well here in Kenya, when you say the bus comes at 9 am it should and if it should leave 30minutes later there should be no issue, but that rarely happens here. The traffic jams in the city break your nerves. It was estimated that Nairobians lost an hour a day in the traffic snarl ups. That is why I say there is nothing comparable to international exposure, to witness that systems can work and they do, it's a very humbling experience. The more perspectives one has on an issue the more likely their critical thinking as well as being pragmatic solution providers'. Where he worked he claimed it was possible to cover a total of 2000km in 48 hours part timing. Waaoh! As to whether this hands off would mold the students into better health care givers is a discussion for another time.

Non-teaching teaching staff

Universities in Kenya had continued to use a section of their nonteaching staff and technical staff on an internal part-time basis to cover for teaching staff shortage. As to whether this made economic sense is a matter beyond this scope. For one to qualify as an internal part-time lecturer one required to meet the same qualifications as would the teaching staff. It had become increasingly common to find a nonteaching staff who apparently had more units on their hands than their teaching staff.counterpart. Some of these were usually what teaching courses that most teaching staff regard as inferior or else what no one wants to touch. Anecdotal evidence showed these were scheduled on Monday mornings and Friday afternoons or other considered 'inconvenient times'.

A friend who now works as a private nurse practitioner gave these words of advice many years ago and I still follow them today: "They (patients) don't care how much you know as long as they know how much you care".

The patient will notice the difference between the health care providers with a false smile, one who says without meaning it - 'If you need something please let me know!' versus the nurse who is in touch, who is there for them, does something helpful even without asking/being asked to. They are able soon after admission, to differentiate the regular ward nurse and this 'big nametag-bearing nurse with a clipboard', 'who walks the corridors and not by their bedside' who is not of much use to them.

Some colleagues used to refer to these breed as 'sterile nurses' that is, they would not want to get their hands on the patient. They occasionally strut the ward aisles, manage

students from the hospital and corridors rarely next to a patient, fear to talk aloud in case they might be saying ('teaching') something outdated or eccentric, behave as outsiders looking in. This author participated in a multisite international study (McEnroe, et al 2016). Some of the questions included in *Nursing students' caring behaviour as an outcome of instructors' caring* was - "Spends Time with the Patient".

Another one said of some nurse educators - *who are 1km wide and 1cm deep knowledge-wise.* This type might teach well but when it came to testing – there was a big gap on examining what had been taught. There was a lot of recycling of past papers. They at times appeared to have no idea *of the what's or how's to* be examined in the practicums of the courses they themselves taught.

Going forward, I guess no discipline would wish for a disconnect between theory and practice and nursing in Kenya is no exception. This is one undesirable direction it could take and it has to change or else…

Just like we mentioned above concerning patients. It does not help the students much that the teacher feels himself like an overspecialized academician. The academia cannot forever dwell in the past as if it was the desirable constant. Just like many other fields today the profession may not care about what one did in the past in academia (unless it has really made a big difference in the lives of others).

The fraternity yearns to know what you can do for/in the future; 'you are as good as your current assignment'. What transferable skills for students or to anyone you got? Critical-thinking skills, networking skills, interpersonal skills, team work, and results etc. Keeping in mind that the more effort and work you put in collaborations the more you will get out of it. We need to give our graduates the ability to be able to take over the mantle of developing Kenya and the region.

But then there were other skills that had been explored elsewhere and found to be quite useful for the students' future. According to Dr Bitange Ndemo[78], an ICT expert and Associate Professor University of Nairobi it was about time our education system started giving the young minds on how to code which was a powerful thing in the era of digital transformation. This was useful in what had come to be referred to as the 'Gig economy' – where one could receive compensation for one key performance as opposed to being an employee etc.

This author felt that for a resource-constrained setting like ours, a career program like nursing needs more caring nurses to teach it. Can our educators shine through in the caring attitude? We can ill afford to delineate the practice from the tutor nurse.

It would not be good for us and the future of nursing for our country. Already cracks have started showing and it could get bad and the patient might fall through: Why do several BSN students abhor clinicals? A clique of soon to graduate BSNs was contemplating doing away with the 1-year internship; a memorandum to this effect had already been discussed at high levels around September 2015.

Anecdotal evidence showed that even though for many it was clear that there was a job market for MSN prepared nurses, many BSN graduates especially those graduating from Kenya's public universities go on to do graduate degrees in other disciplines. They have used a nursing degree as a stepping stone to something else.

It had also become clearer that most of the faculty positions in public, as well as private

universities in Kenya were held by those who got their undergraduate BSN from private universities. The same might be said of nurses with degrees in the country's healthcare system.

At the risk of being accused of being biased, this author observed some kind of cycle-in-cycle-out phenomena: BSN graduates from private universities practice nursing in the public health care system, go on to public universities for MSN, go to teach in a public universities (as well as private universities). As for BSN graduates from public universities, few were to be found in Kenya's health care system or practice nursing, a few do MSN and then teach (mainly in public universities), a sizeable number go on to do graduate studies in non-nursing programs or exit nursing altogether. This pre-2015 trend may change as more of them graduate from the 21 or so BSN-accredited universities.

Fewer graduates from public universities secured jobs in nursing practice and it took more years on average for them to matriculate into a Master's Degree program compared to BSN graduates from private universities who registered sooner. The whole line of argument might apply to nurses who upgrade in RN-BSN programs. This is an area that needs some research from several angles.

A good number of BSN's were opting to go for the one year Higher Diploma (tailored for basic diploma holders, offered in Medical Training Colleges) in specialized areas like critical care, nephrology, operating room nursing etc. The effect this might have was yet to be ascertained.

It would be advisable for the faculty to reach out to this critical group, recognize them for who and what they are, pay them in commensurate and develop them. Some of them possessed the higher diploma(s) before getting the BSN and apparently had plenty of knowledge. They are a treasure that could be reasonably tapped.

May be it was about time we started recruiting for nursing from other undergraduate programs in Kenya. Borrowing from what was referred to as Healthcare Interest Program (HIP) the University of Colorado Denver. HIP is a pre-health pipeline program for undergraduates interested in a healthcare career and it involves mentoring, clinical shadowing, monthly didactics, and opportunities for community outreach and clinical research.

This Hospitalist mentoring program was tailored to sustain interest in healthcare careers. This is a year-long, comprehensive program called the Healthcare Interest Program (HIP) that included pairing each student with a hospitalist for mentoring and job shadowing. At the end of the first year of HIP, students were surveyed, and 2 years later they were contacted for follow-up.

[78]Dr B. Ndemo, Develop digital skills among our youth. *Business Daily* 30th Aug 2017. businessdailyafrica.com

Cervantes *et al* (2014) did a study with 26 HIP students, they found out that 95% remained committed to a career in healthcare, 86% had graduated, and 29% were enrolled in postgraduate healthcare training. The program was also recommended as a good way of recruiting minority under-represented groups into healthcare careers.

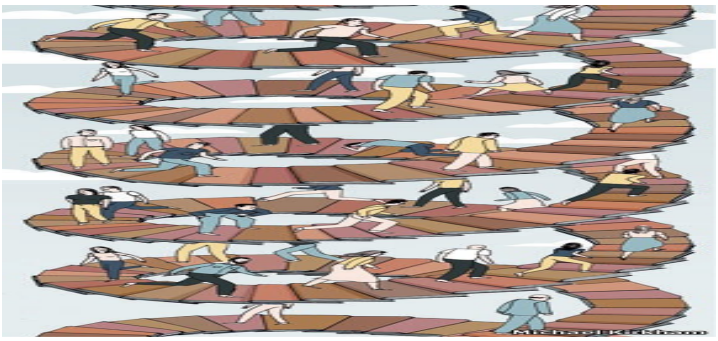


Fig: Academic excellence in nursing sciences for quality health care(Adapted from Michael Kirkman)

17. 9. 3 Epilogue

I have reserved the best for the last. This epilogue can be best understood when read in the same context as the preface at the beginning of this book. As we interrogate the quality of health care we provide in our settings we must ask questions: the risky, the unaskable and the unmentionable ones and also be part of the solutions.

Some we can only ask and pause at the same time. In journalism they say *do not ask your readers questions, it is your job to find out and tell them*. But then flagging out issues as was being done in this book cannot be the same as asking questions in a controlled environment nor were some of the questions upto scratch as would by a panellist.

Someone commented that if you ask a stupid question you look a fool for only 5 minutes but if you fail to ask you remain a fool forever. Indira Gadhi said that 'questioning is the key to all progress…' This author comes from the school of thought that questions may even tell us more than answers would. Nevertheless the writing did contain some of the answers to not only the issues raised but to others too. I believe these required an independent mind.

Some of the things discovered during these recollections undertaking of interrogating health systems in resource-constrained settings were encouraging, borne out of creativity and resilience. Quite a number were heart breaking though. The suggestions put across some will say were easier said than done, but it's a matter of trying, what if it works. For a good number though there is evidence that they do work elsewhere, but then can they be transplanted?

It is humbling to admit that some nondescript individuals who asked the right questions brought the world some of the innovations we have today. Yet, no one ever had all the answers and so this author tried but did not have most of them. We need to access these answers, the information, the resources etc.

We need to input our commitments and efforts in a more significant manner. We must build relationships within our teams and stakeholders: by supporting the staff to help them grow. In taking risks, tinkering, creativity, continuous evaluations, allowing for open and vulnerability leadership, with a resilience that has brought many developed nations to where they are today.

It is this author's believe that if these ingredients are put in place we have great opportunities to improve the quality of health care at the entity level and across the system. If the solutions were straight forward the health care system would be on its way to being fixed but that is not the case. However, with more effort, I think we could have had a better health system than we now have.

Apparently, the average consumer of health care was neither used to raising or consuming questions (A) nor looking for answers (B). How do we inculcate in (A), a move from (A) to (B) and vice versa?

Posterity can muse upon whether the quality of our health care improved with yet another framework or by understanding the reality of what we are seeing by asking questions (asking who? Who cares? But why - some might ask. What if there are no answers?).

Ask the right questions. Not everyone will give you answers. Infact quite a number would not be bothered, while the rest would rather you didn't ask.

What Now: Another Framework? Should it rather be "What problems can we solve" rather than "what model/framework do we want to have"? A framework or a book for that matter alone is not the change we seek in the health system in Kenya and other low-income countries. It is another chance to make that change, but that cannot happen if we go back to the way things were.

According to Kenya's Vison-2030, this shift will involve moving from a limited sense of urgency to relentless follow-up; from slow reactive to fast paced mechanism of handling issues; from low and dispersed to high ring-fenced budgeting; from the shortage of skills to war for skills. Namely - from business-as-usual to business-unusual.

There is a bespoken functionality in asking questions. All around us we have ready access to people who are actually doing what we are doing, what we are interested in: our team members, collaborators, online blogs etc. Ask them.

Papers, books tend to tell you how to do something, but don't give you a sense of what it is to actually do that something. But then what options are there if we don't ask? Some of the practices that were assumed to be cast on stone may actually be inaccurate, a good number have reached us through perpetual duplication of misinterpreted, misdocumented information.

There is a saying that "a nurse knows that a nurse that knows everything is a dangerous nurse". I say keep on tinkering, asking questions and you will go far! Don't fall into the trap of thinking that your non-expert questions will annoy the experts; they can answer at their discretion. Let them see it as flattery if that is the lowest they can.

It may be true for many challenges highlighted here could be traced to uncoordinated leadership and uncoordinated resource allocation in the health sector. Someone somewhere might suffer or die because of the decision we make or lack of it on our part. For the rest (and that includes us and everybody else), as someone put it, we will be killing them softly.

That is why in resource-constrained settings we need to continuously query the systems. The day we stop doing that is the day we start doing everything electively, optionally, but health care rarely accords us room for such indifference. In all the cited explanations in this book, a good number were system related. Luckily most have since been rectified. This author had no reason whatsoever to accuse anyone but where need be there might be

ground to investigate and take corrective measures.

It is not necessarily that the questions asked are directed to others. Infact far from it, the solutions must first and foremost come from within. Falter (2012) wrote, it does not help much when a "we/they" thinking creeps into our understanding of our own leadership role. *They are leaders, I am not.* We need to *turn on the leader light bulb in all of us* (Falter Elizabeth was the executive director of the Arizona Healthcare Leadership Academy, US).

Accordingly, she said, "I believe nursing leadership begins at the bedside. Whether you are in charge of 5 patients or a staff of 50, leadership skills are necessary to achieve quality outcomes. There are many outstanding emerging leaders if only they did their part, emerge from the bubble.

The human mind is a great source of information, may be better than any other. We query the mind by asking ourselves questions and challenging it to come up with answers[79]. Our minds will give us amazing answers, usually relevant answers that are related to our needs. Why relevant?– because it understands our situations and circumstances better than anything you might get from online, books, journals etc.

In many African cultures there was this belief that no event had one version as what happened. The stories could vary depending on the beholder. Stored up in our minds are observations, experiences, lessons, locally available resources, what works and concepts that we have internalized. These can be brought up using critical thinking, meditating or just stepping back to assess the situation among many other techniques that psychologists talk about. Let the mind of the health care providers do the thinking.

By working together with others we can create environments where ideas can connect and people can collaborate. The options we can generate together would be unlimited to help us face or solve perennial challenges.

If indeed the scenario can change overnight just because a dignitary was visiting our facility or there was a visiting team for a surgical camp, then there was no reason why that one day cannot be sustained into many more. Just wondering aloud - what is so difficult about that? After all, it's the people that matter, the people of Kenya and not any dignitary. (More on this was covered in section 6.5.3 Construct No.3. **When does the quality of care become a concern to us?**).

There is an urgent need for refocusing action to ensure that change results into better care for the people who are the focus of our work. Each of us has experiences that can be compiled and put into context and who knows - several other volumes like this one are awaiting to be written. The value of information can never be underestimated in this age.

If we add evidence-based practice (EBP) to great people and great books, we will grow! Many times the vision, mission, and burden of assuring quality health care to our people in resource-limited settings will have to be accomplished in the solitary places, where it is only you the care provider (or your team) to make a difference, on the journey to bettering our lot.

History has proved: That one man/woman can make a difference! … In a unit/ward. . . In a health centre . . . In a hospital… In a health care system…In the world. In all of the eternity.

The legendary French aviation pioneer and author Antoine de Saint-Exupйry (1900-1944) as quoted by Stephen Few (2004) in *Common Mistakes in Data Presentation* said, "In anything at all, perfection is finally attained not when there is no longer anything to add,

but when there is no longer anything to take away". This is a guiding principle in communication and as such there could be better ways of putting these together.

Social media has apparently has been cut out for more people to express themselves, but only a few bloggers coming from low-resource countries dare to touch health care, yet this is an overripe untapped area where unconventional book writers like this author can tap from.

Once a blog is up and going, it is more than worth it in terms of financial returns commercial advertisements utilizing search engine optimizers (SEO) like Google and Bing were looking for high volume (must read) websites to promote their online shopping products. I regularly snoop around one Brittney Wilson, BSN, RN *nerdy nurse* blog http://thenerdynurse.com.

Nerdy nurse is a living proof that *what's on your mind,* experiences we have are worth more than we will ever get to know (see **Nerd nurse** in Chapter 16). *WordPress* is an open source software and can be used to create a beautiful website, blog, or app. It might be helpful to join *nurse blog support* on social media. One of the founders Ashley Pofit, RN runs regular opportunities to expose their *nurse by heart* articles.

Compleat Health Systems http://www.compleathealthsystems.com is a blog that this author runs. I also post on social media using the name *Compleat Nurse* is a living testimony. A lot of the stuff I have shared in this book show were hatched in the blog and vice versa. A blog is a good testing ground for your ideas.

A lot will always be left out within the constrained space of a journal article. I have sampled a few articles that I have authored (but most of them with others) for my readers for the following reasons: one to show them that it can be done and two it does not have to be a lot of work though you might need some help or work as a team. It might seem hard to start with, but just run along and never behind.

No one person can ever be a - been here, been there and seen it all. Infact someone said that one is too small a number for greatness. That is why this book incorporated *voices from the field* in a very big way. It would be great to hear what others think, to have another version, anything but silence.

I believe that information, or the lack of it, is the really critical factor in judging any issue of public importance such as healthcare, which continues to be a going concern for consumers and providers. More critical was reading a lot, listening, asking, picking cues from wherever, having a third eye to observe what goes on around us, having the language and the articulacy of putting it across. Giving experiences, words new meanings.

[79] *2 Minute Sense*, WTV 21st Feb 2015, 20Hrs

Perhaps using long words to name little things, or used little words in a big way. Either was hard to do – i.e. when you know what you mean but it's hard to say what you mean – paraphrased from SSC Booknews (July 1981). What started as reflective journals and field notes transformed over the years into this book. In the words of Mark Twain "*…brevity is indeed an art and a skill! I didn't have time to write a short letter, so I wrote a long one instead*".

Lastly, remember that you cannot expect to get all the credit no matter how original the idea/action you had was. Someone somewhere will want to take it. Managers, politicians especially would like an idea that they can pick and run with it, get the credit.

The same way they sometimes like it when someone picks ideas from them and runs with it. But so what? If you got something for the patients and your colleagues in the process, that is something to write home about. Maybe not as awesome as you thought, but so much for that even if it might not seem to contribute something to the state of the art.

This author was amazed by the volumes of reports, manuals, frameworks, models and concepts on Kenya's health systems, much of which was donor-funded work. How have they helped us deal with the hard and soft issues (raised here and elsewhere) in the short and long term?

What became apparent (and this applied to many of them) was some disconnect with each other. They ought to speak to one another. The models and frameworks ought to make (or have made) a difference in identifying points where we believe the trajectories give us the best chances of succeeding. Why was this not the case? Nevertheless, the availability of many of these documents freely as PDFs and linkups were most helpful. Each of them provided credible soundings for me while writing this book.

Resolving some of these concerns requires a coordinated response from a variety of stakeholders representing all levels of the healthcare system and even beyond. But it begins by asking, seeking to find answers, engaging etc. By being with people in the moment, trying to understand what they think and feel about the issues. Being with them in their time of need, on their way to work, in the workplace, their homes, or at an event.

What has been the people's journey up to this point, and where were they going? What was important to them? It's the people that matter! and *it's the gravity of the weight of the matter that matters*, as one of my mentors used to put it.

Like a longtime friend turned motivational speaker/writer Radido Dooso wrote - *I am the author who wrote a book so I can learn from its contents.* This book apparently has been about *everything.* As a student of leadership in health care systems and until I know what it's not, I see that everything matters. Hopefully, I have not explained myself too thin. Like many new authors, getting published is a dream that got started with diary, blogging, ghostwriting, and reflective notes. None of that compares to the thrill of seeing my name in a printed book.

Delimitations & Conflict of Interests

The author declares no conflict of interests. Some emergent issues as well as coincidences came through scanning current affairs, learning from real life scenarios. Made relevant applications to the professional work environment and specific career challenges and citizens' aspirations which this author believed were unique to resource-constrained settings. As for the people involved – all attempts were made to describe them by their role rather than by name, except for exceptional cases.

Due respect and considerations were accorded to trade unions, colleagues, supervisors, healthcare providers, faculty, patients and subordinates as key types of individuals used in perspective. No harm or malice was/is intended to any of the individuals, their office or organization mentioned here.

Attempts were made to reach original users of graphics, frameworks, and models inserted

in this book and where this was possible permission to use them was sought for and granted. In all other circumstances under the fair dealing concept, the owner of data was acknowledged. Excerpts from social media, concluded court cases, legislative assemblies, mass media, and the press releases were assumed to be in public domain.

The book contains affiliate links and hyperlinks in text and in the references. Efforts have been made to ensure that the links worked and were not broken by the date of publishing. This style of writing would become a great resource to those who will use the Kindle edition or other authorised forms of soft copy.

I would be proud if the frameworks originating in this book were interrogative and representative of health systems in resource-constrained settings. It is indeed a privilege being able to say that. The frameworks may not nearly be as great as finding the next cure for cancer, but it was really important to take that bold step.

Please, anyone, jump in if I'm wrong - and I'm sure you will hopefully not by analyzing every text and byte but the spirit. Certainly the fabric here is not suffiient to come up with a complete suit called the health system. Go ahead and test these ideas (of course with necessary acknowledgment to copyrighted property). Do a review or make a verdict as a reader, user etc. Visit my blog and follow, tag; subscribe to keep update with some of my work. I can comfortably conclude that Kenya's health systems will continue to be a going concern.

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APPENDICES

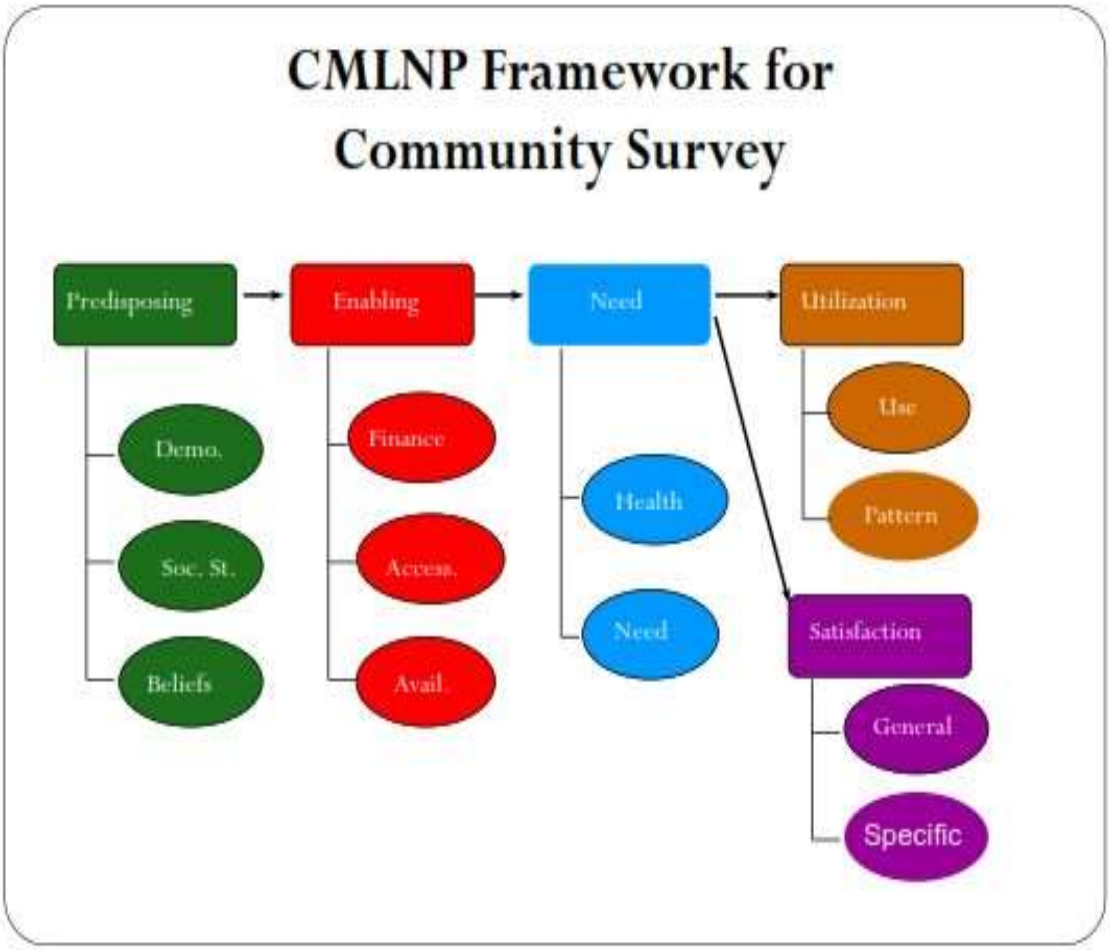
Appendix 1

Community Perceptions about Good and Poor Quality Health Services

Good quality services	Poor quality services
*Good sanitation in the facilities	*Poor sanitation in the facilities
*Sufficient health workers	*Inadequate health workers
*Sufficient drugs, supplies and equipment	*Shortages of drugs, supplies and equipment
*Short waiting time	*Long waiting time
*Counselling about preventive care	*Inadequate/no counselling on preventive care
*Services for the poor and elderly are available	*Lack services for the poor and elderly
*Good referral systems with transport	*Poor referral system without transport
*Polite and courteous health workers	*Rude health workers

(Source: Patient Preference and Adherence, 2009, DHS)

Appendix 11

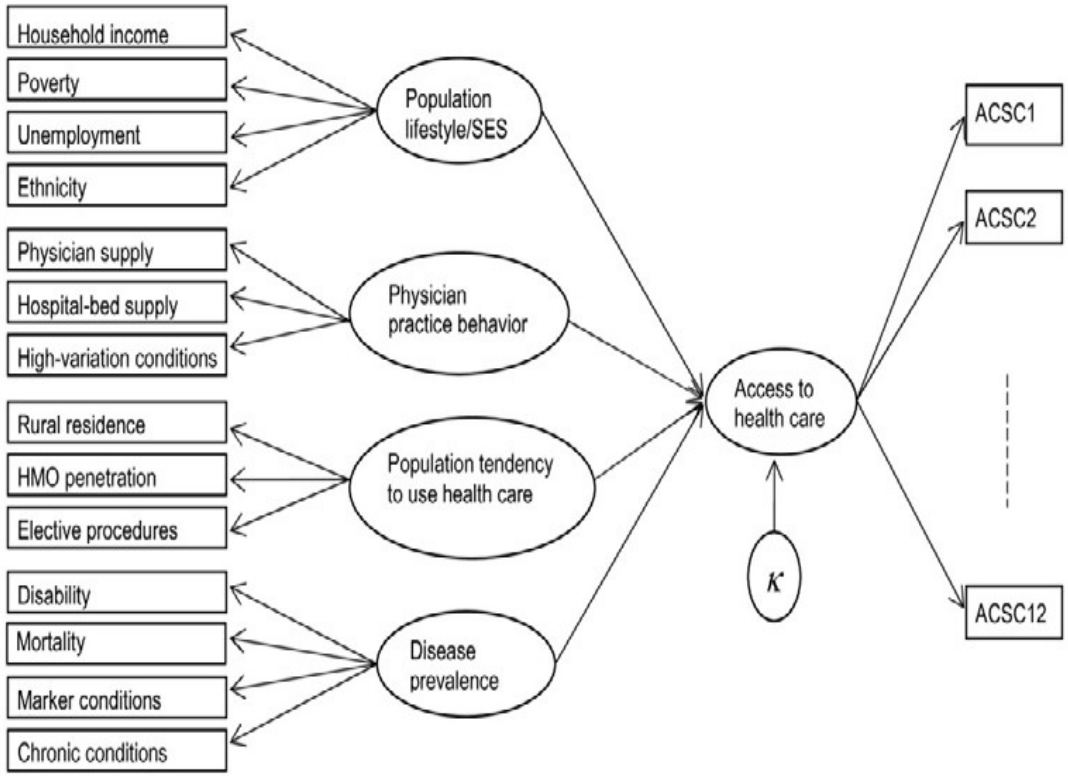


CMNLP-Comprehensive Nursing Practice Model for Rural Hispanics Access-accessibility, Avail-availability, Demo-demography, Soc.st-social status

(Figure used with permission from author Dr Joyce Verran)

Appendix 111

Conceptual Model to Assess the Underlying Factor, Access to Health Care.

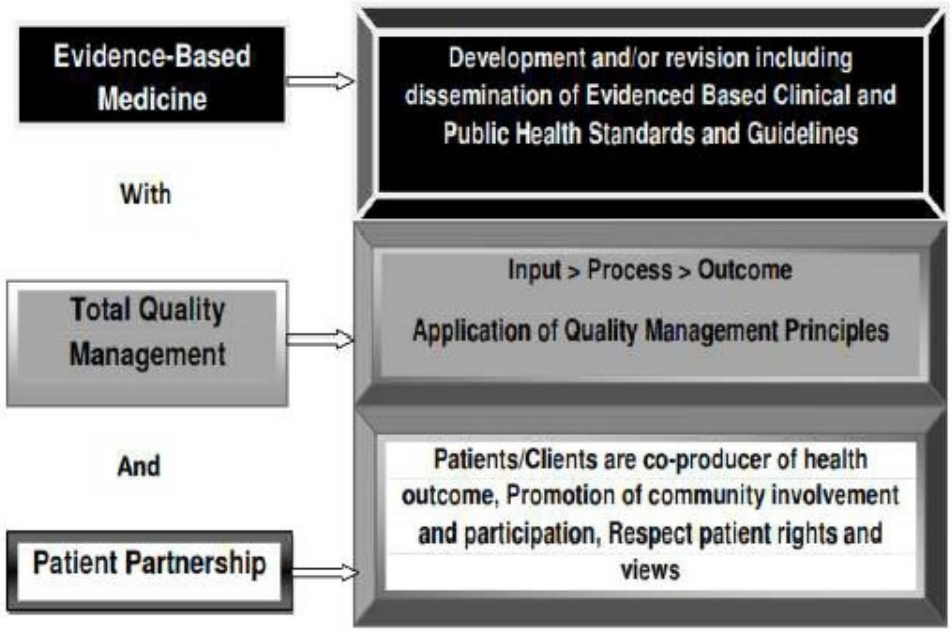


Key: SES-social economic status, ACSC-Ambulatory Care Sensitive Conditions, k-constant

(Source: Hossain and Laditka (2009). International Journal of Health Geographics, 8:51)

Appendix IV

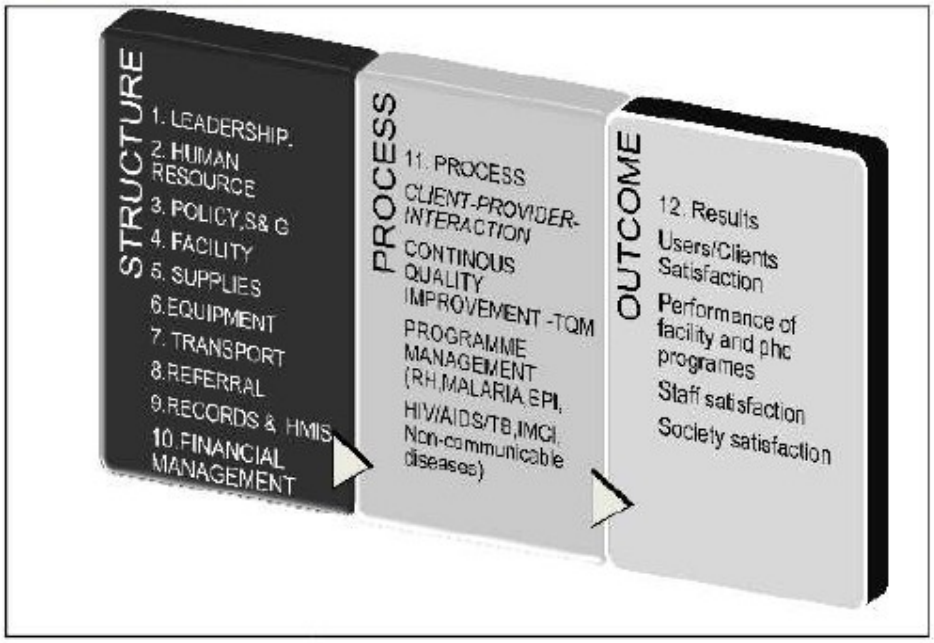
Diagrammatic representation of the KQMH model



(Courtesy of KQMH, 2011)

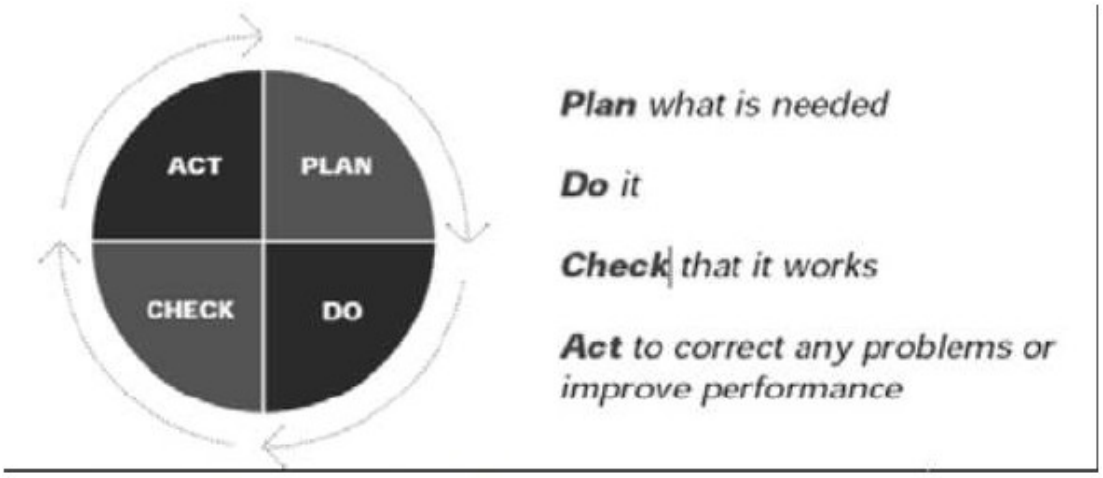
Appendix V

The KQMH has articulated quality standards in the 12 dimensions of the health system.



(Courtesy of KQMH, 2011)

Appendix VI



The PDCA or PDSA Circle developed by W. Edwards Deming.

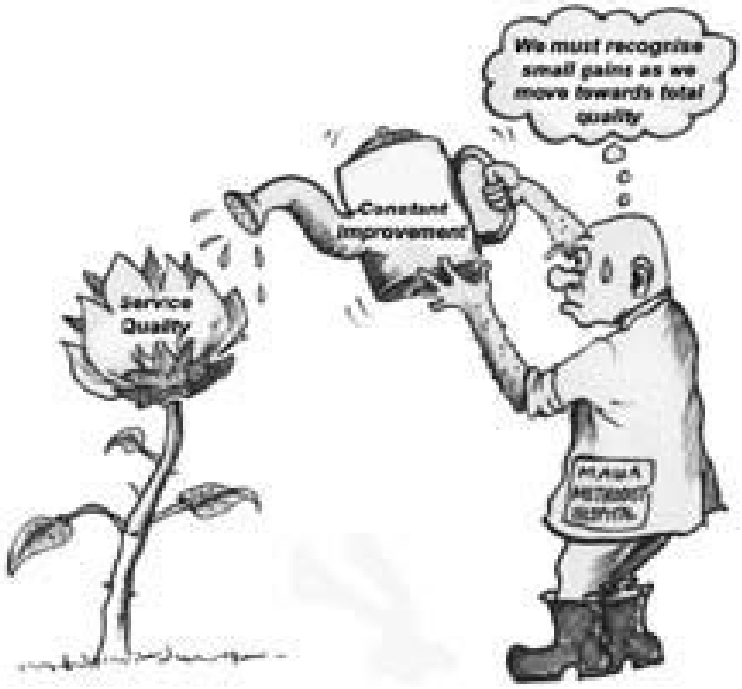
Appendix VII: The author's experiences in the Kenya health care system

Station	County	Period	Status
Kenyatta National Hospital	Nairobi	1986-1990	Student KMTC Nairobi
		1996-1997	Student KMTC Nairobi
Moi Teaching & Referral Hospital	Uasin Gishu	2001-2011	Staff
		2003-2007	Student Moi University
Rift Valley Level Six General Hospital	Nakuru	1992-2001	Staff
Aga Khan University Hospital	Nairobi	2000-2001	Pool nurse
Kericho County Referral Hospital & Kapkatet Sub- County Hospital	Kericho	2011-to date	Supervising BSN students- University of Kabianga
Londiani District Hospital	Kericho	1990-1992	Staff
Kapenguria County Referral Hospital	West Pokot	2006	COBES IV/ student Moi University
Karuri Rural Demonstration Health Centr	Kiambu	1988	Community health nursing attachment KMTC Nairobi
Tenges Health Centre/ Mugorwa Health Centre	Baringo	1992	Yellow fever campaign
Sirisia Health Centre	Bungoma	2003	COBES I/ student Moi University
Turbo Health Centre	Uasin Gishu	2004	COBES II/ student Moi University
Mathari Mental Hospital	Nairobi	Now and then	Student, Tutor, Lecturer
Njoro Health Centre	Nakuru	2008	Internship after BSN
Koiwa, Ainamoi, Mogogosiek, Cheptalal Gesima, Manyoror, Sosiot, Roret, Esani, Ndanai, Health Centres & Sigowet, Meteitei Sub-County Hospitals, Alupe su County Hospital, Port Victoria Sub County Hospital.	Kericho, Bomet, Nandi, Kisii	2011-to date	Supervising COBES BScN & BSc EVH students of University of Kabianga
Longisa County Referral Hospital, St. Clare Mission Hospital Kaplong, AIC Litein Mission Hospital	Bomet, Kericho	2016-2017	Supervising undergraduates students on clinical practicals

i COBES: Community Based Education & Service

Appendix VIII

A Quality Care/Service Cartoon By Maua Methodist Hospital



'We must recognize small gains as move towards total quality through constant improvement of our service quality'
(Courtesy of CHAK Times, used with permission from editor)

Appendix IX

The Fast Changing Patient Care Environment



(Courtesy of Google images)
(Used with permission).

Appendix X: A Letter to the County government-Empowerment of the community with devolved government(Adapted from *Footsteps* 93, www.tearfund.org/tilz)

Organization ….

C/o … Sub County Hospital P O Box ….

Contact person… Phone No.

Email:

Date…

Dear Chief Officer Health and Finance,

… County Government.

I am a member of Chama Cha….. Community organization…. On behalf of …..I thank you for representing us in the COUNTY government. We would like to support you and work together for the good of our community. For this purpose we request copies of policy documents and budgets owned by the ….. County relating to –health-education-water-farming and agriculture. The main focus of the organization is community health.

Does any process currently exist for involving the community in planning? If there is a process we would be pleased to know about it. If you could send information to the above address, we would be very grateful. If you do not have access to the relevant documents I trust that you will pass this letter to a colleague who can help.

We look forward to receiving the information in the next month (by end of May….). We would be pleased to offer advice on how the County government money can be used more effectively on behalf of the community. More especially the health of the people of ….. We have about 10 community health units. Our landscape is a hilly settlement scheme. We have a vision of starting a 40 bed home for mothers who are expectant to be near the health facility whenever they might have difficulties accessing care.

Thank you in advance,

……..

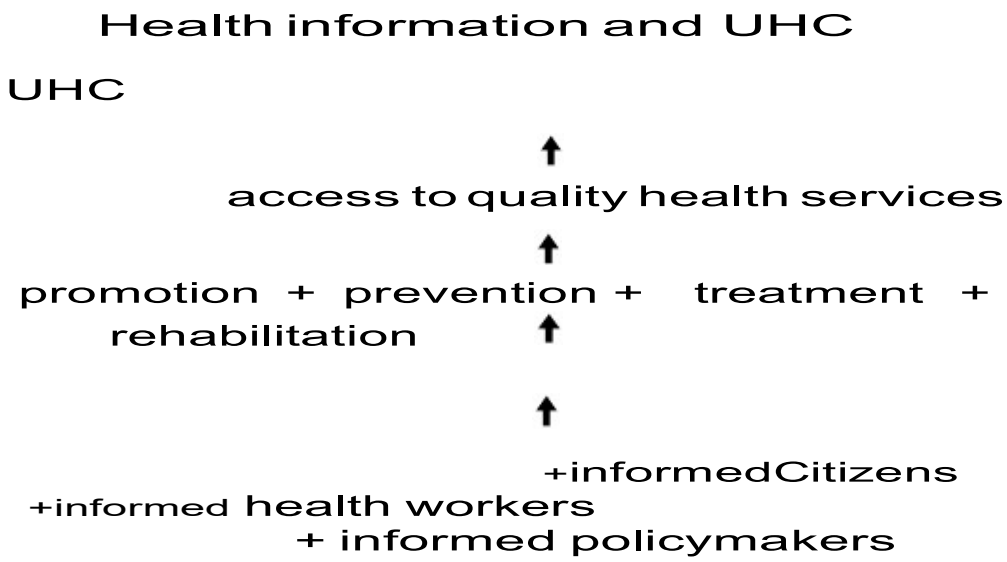
Coordinator

On behalf of …. organization …

C.c-File copy, MCA Sub County

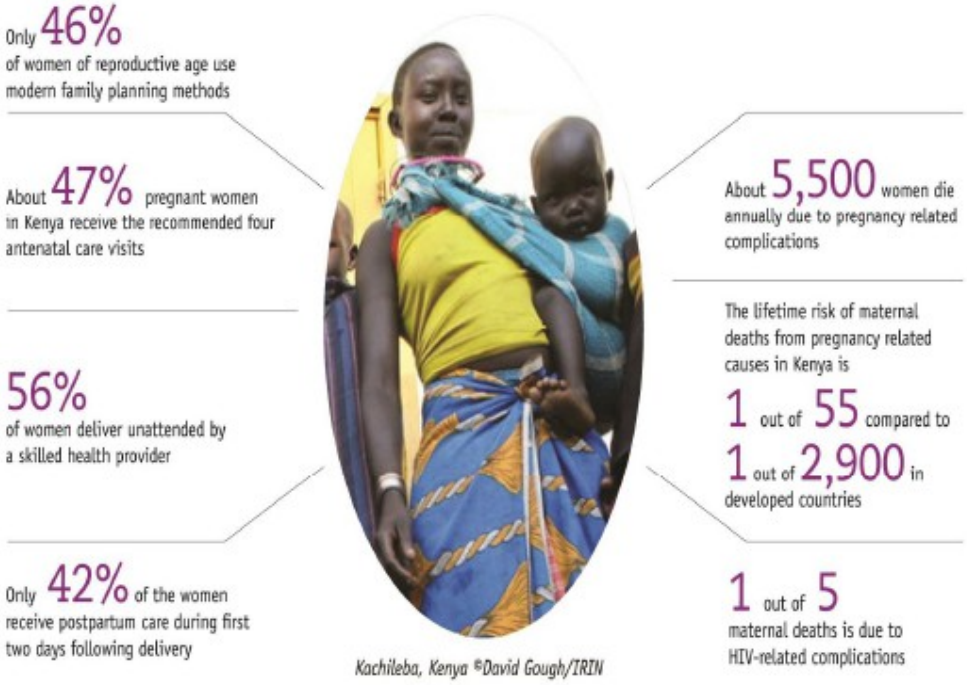
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Appendix XI



Key: UHC- Universal Health Coverage

Appendix XII : Overview of Maternal Health in Kenya



(Courtesy: Kacheliba, Kenya David Gough/IRIN)
(Used with permission).

KENYA TOP 50 CAUSES OF DEATH
AGE-STANDARDIZED DEATH RATE
PER 100,000 POPULATION

TOP 50 CAUSES OF DEATH	Rate	World Rank
1. HIV/AIDS	293.53	12
2. Stroke	116.62	75
3. Coronary Heart Disease	101.18	108
4. Influenza & Pneumonia	93.64	51
5. Diarrhoeal diseases	56.98	41
6. Diabetes Mellitus	42.44	74
7. Lung Disease	35.98	63
8. Tuberculosis	32.61	51
9. Road Traffic Accidents	28.21	40
10. Violence	25.77	24
11. Maternal Conditions	23.18	25
12. Hypertension	21.81	121
13. Other Injuries	21.65	36
14. Kidney Disease	19.59	77
15. Birth Trauma	16.45	33
16. Low Birth Weight	16.26	51
17. Breast Cancer	15.76	102
18. Oesophagus Cancer	13.93	8
19. Endocrine Disorders	13.60	59
20. War	13.35	10
21. Asthma	11.97	52
22. Inflammatory/Heart	11.31	64
23. Schistosomiasis	10.84	10
24. Suicide	10.09	65
25. Trypanosomiasis	9.95	12

TOP 50 CAUSES OF DEATH	Rate	Worl Rank
26. Cervical Cancer	9.74	45
27. Malaria	8.18	42
28. Alzheimers/Dementia	8.00	67
29. Stomach Cancer	7.91	77
30. Liver Cancer	7.20	76
31. Lymphomas	7.09	42
32. Prostate Cancer	6.74	87
33. Epilepsy	6.31	40
34. Liver Disease	5.82	149
35. Congenital Anomalies	5.58	114
36. Peptic Ulcer Disease	5.58	61
37. Meningitis	5.04	60
38. Anaemia	4.83	59
39. Falls	4.65	68
40. Poisonings	4.37	52
41. Colon-Rectum Cancers	4.34	142
42. Fires	4.16	60
43. Leukemia	4.10	81
44. Drownings	4.10	77
45. Malnutrition	3.92	76
46. Oral Cancer	3.91	62
47. Skin Disease	3.69	69
48. Pancreas Cancer	3.66	89
49. Other Neoplasms	3.12	86
50. Ovary Cancer	3.01	56

Source: WORLD HEALTH RANKINGS
http://www.worldlifeexpectancy.com/country-health- profile/kenya

Appendix XIV

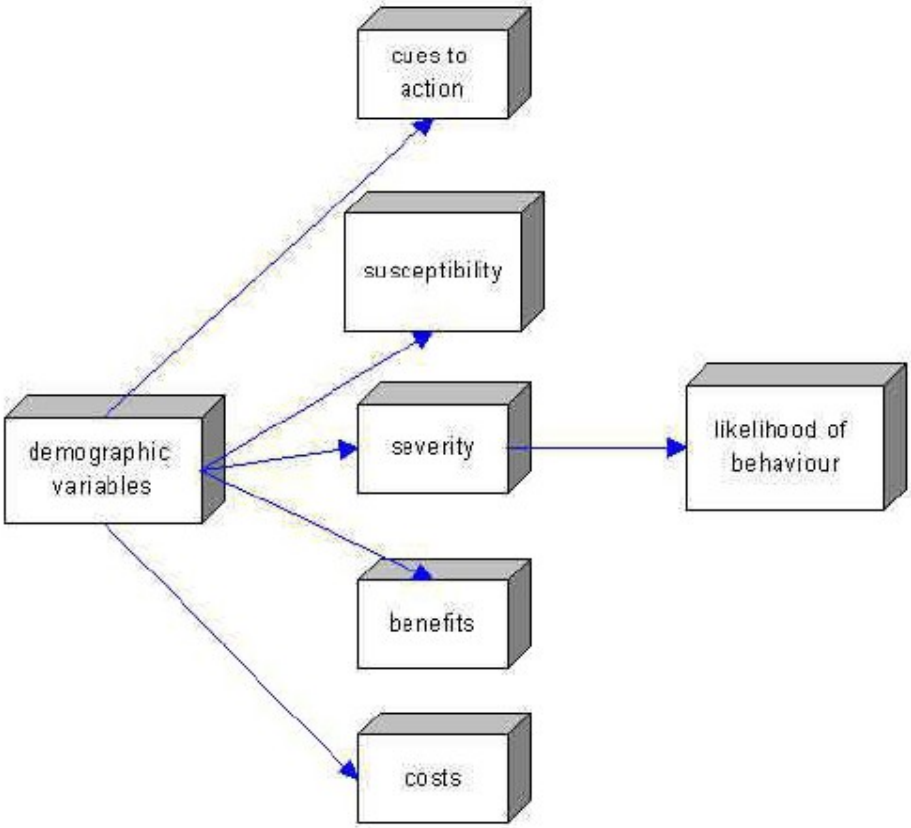
Key attributes of a good manager: Managers should understand what encourages their staff to give their best and what causes disillusionment

Managers encourage the best of their staff by:	Disillusionment and frustration are caused by:
• recognising good performance • being accessible to workers • delegating responsibility • building workers' confidence • promoting self-improvement • being supportive at times of personal and family problems • setting objectives in cooperation with health teams.	• focusing only on weaknesses in performance • unjust and corrupt practices • favouritism and nepotism • poor interpersonal relationships with staff and subordinates • lack of integrity and honesty • poor understanding of problems faced by staff • concentration of all powers with self.

(Courtesy: Community Eye Health Journal, Vision 2020. Vol. 18 No. 56, December 2005)

(Used with permission).

Appendix XV : Health Belief Model

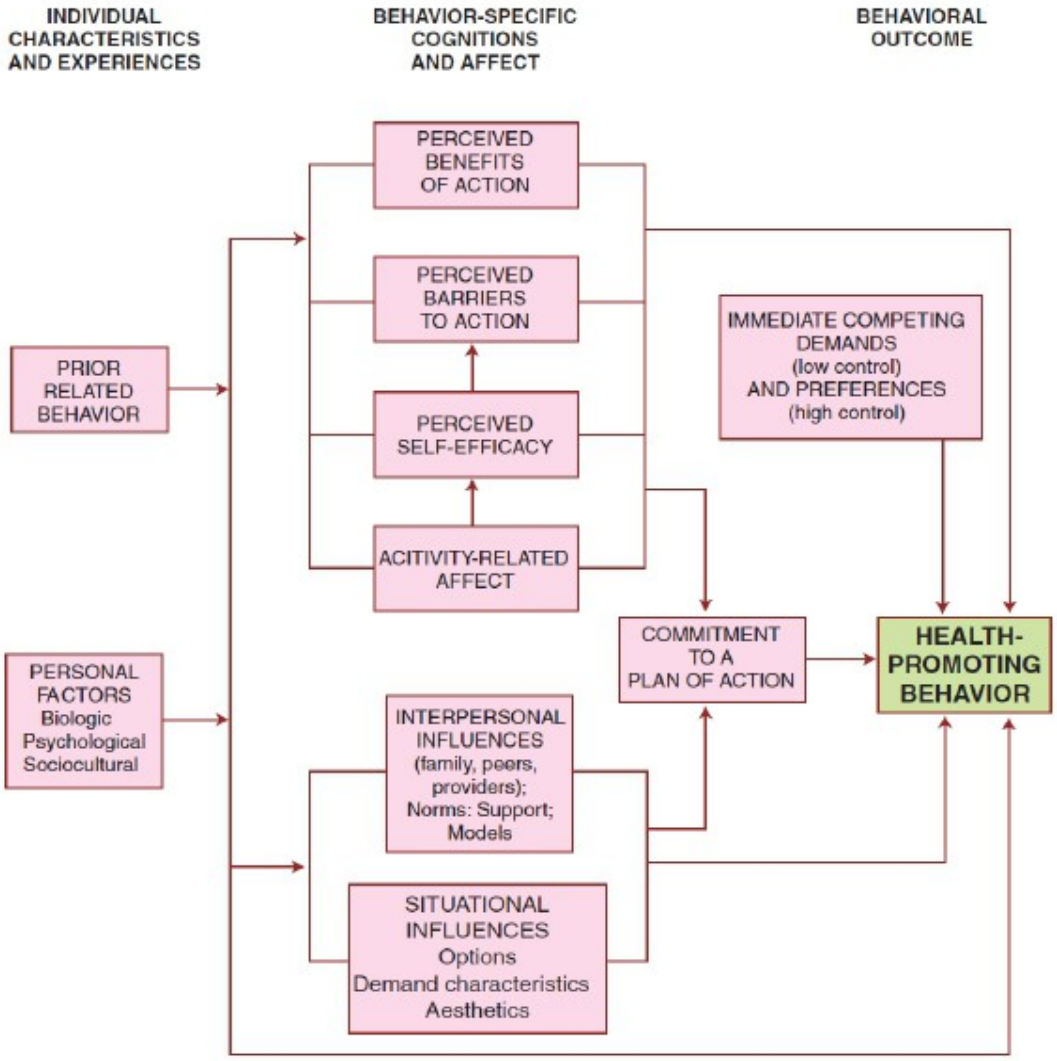


The Health Belief Model (Rosenstock 1966, revised by Becker et al 1976, 1978

Source: Becker, M. (1976). *Health Belief Model and personal health behavior.* Thorofare, NJ: Slack, Inc.

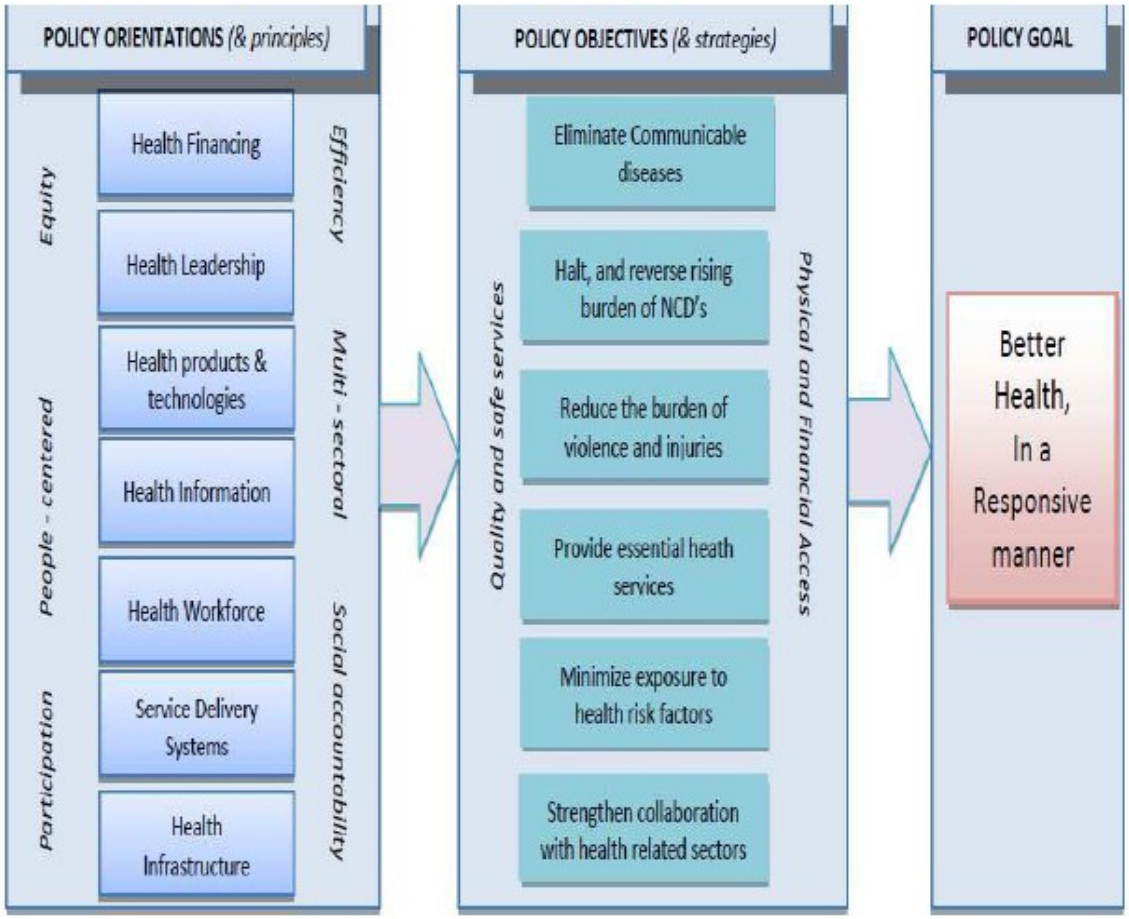
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Appendix XVI: Pender's Health Promotion Model



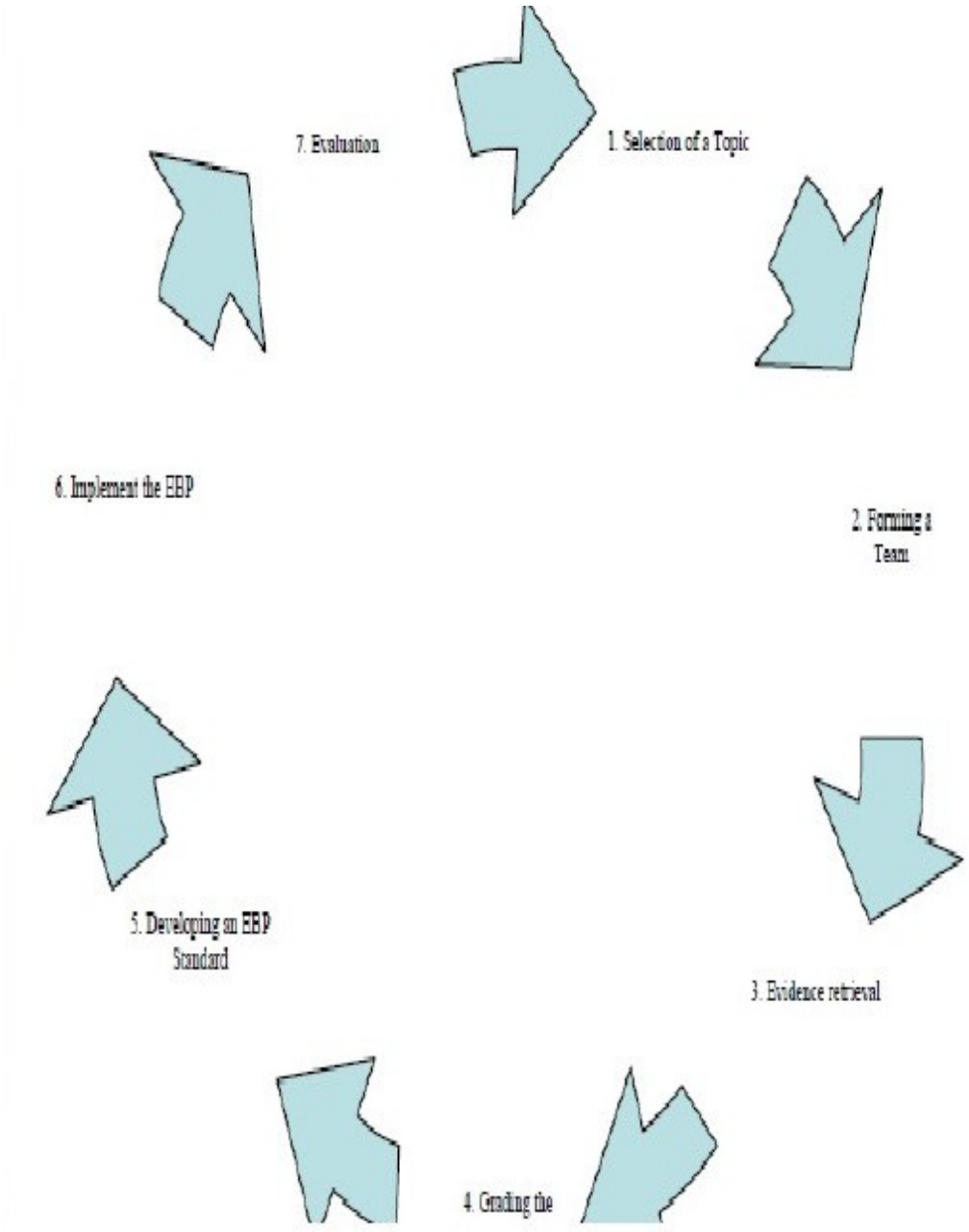
Source: Pender, N. J., Murdaugh, C., & Parsons, M. A. (2006). Health promotion in nursing practice (5th ed.). Upper Saddle River, NJ: Prentice Hall (Used with permission).

Appendix XVII: Kenya Health Policy (KHP)- Framework for Policy Directions



(Used with permission).

Appendix XVIII: The seven steps of Iowa Model



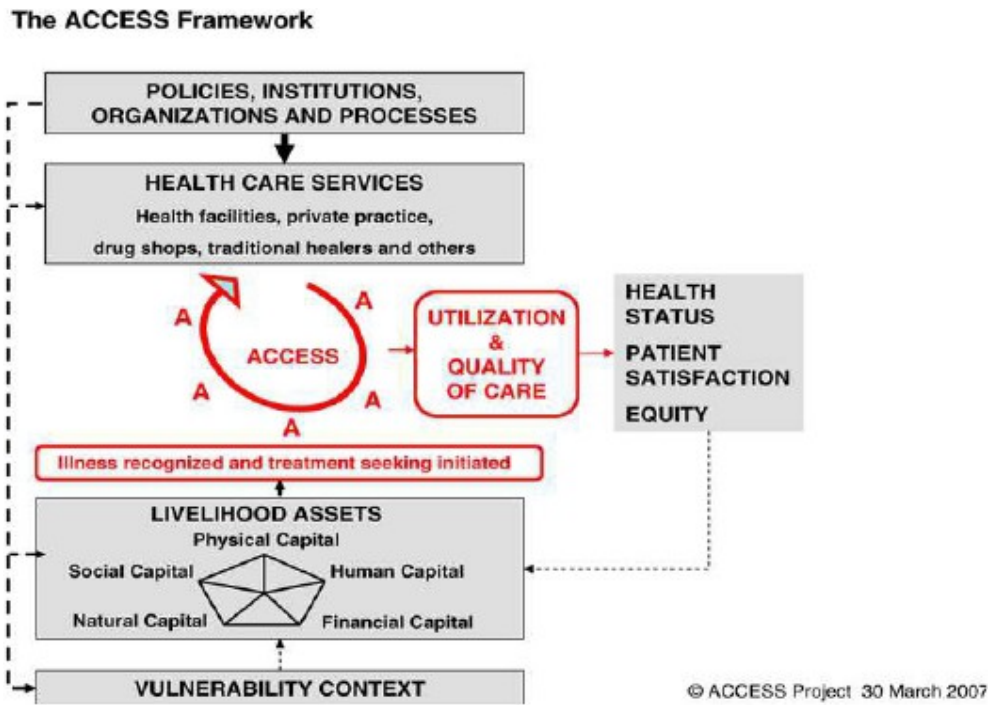
(Used with permission).



Appendix XVIV: Overworked life savers

(Courtesy of Nation Newsplex) Daily Nation May 16th, 2016

Appendix XVV



Courtesy of Brigit Obrist, Nelly Iteba, Christian Lengeler et al., Health care in contexts of livelihood insecurity: A framework for analysis and action (2007). *PLOS Medicine* (Used with permission).



About the author

Simon Macharia Kamau holds MSc Nursing Leadership and Health Systems Administration alongside Innovation in Leadership & Administration (iLEAD) from University of Colorado Denver USA, BSc Nursing from Moi University, Higher Diploma CriticalCare Nursing (CCN) and Diploma Kenya Registered Nursing (KRN) from Kenya Medical Training College, Nairobi.

Ongoing Doctoral studies at Moi University. Alumnus of: Weithaga Boys High School and Muthiria Primary School, both in Murang'a County- Central region of Kenya.

His professional career spans over 26 years. Currently Lecturer in the health programmes at University of Kabianga, Kericho County, Kenya. Previously taught in the Higher Diploma in Critical Care Nursing, Higher Diploma in Nephrology Nursing and Diploma in Kenya Registered Nursing at Moi Teaching & Referral Hospital Training Centre. Was the Nurse Manager of Critical Care Services at Moi Teaching & Referral Hospital, Eldoret (MTRH) for several years.

Has served in various capacities at national and institutional working committees. He served as a guest editor with *American Journal of Nursing Science*, and *Nursing Education & Research,* a reviewer for *Human Resources for Health Journal* (HRH) and *Kenyan Nursing & Midwifery Journal* (KNJM) among others. Has published and presented at both local and international forums. He is a member of Kenya Association of Education Administration and Management (KAEAM).

The readers can follow this author's blog posts on social media http:// www.compleathealthsystems.com as *Compleat Nurse*.

He has also authored three other books:

(1) *Inventory on Job Description of Nurse Managers in Developing Countries: Rising above the Challenges and Demands Placed on The Nurse Manager in a Changing Work Environment* (ISBN 978-3-659-17612-8).

(2) *Ethical Dilemmas on End of Life Issues Vs. Faith of Clinicians in Kenya* (ISBN 978-3- 659-42049-8).

(3) *English/Kiswahili Medical Glossary: Matumizi ya maneno ya Kiswahili katika utabibu Hesperian Health Guides*

Working on another title *Dilemmas on End-of- Life Issues: Challenging Medical Ethics, The Law and Faith as a Christian Health Care Provider in Kenya*.

Has published widely, online URL:
https://www.researchgate.net/profile/Simon_Kamau/publication s/

Key Features of this book*:*

-Distils lengthy and complex systems/quality health care frameworks and models into bite size pieces of clear, concise information, making them easier to embrace and incorporate into practice in resource constrained settings;
-It is a practical book providing quick access to several policy matters on health care in Kenya and the rationale behind them. This is neither meant to be prescriptive n or all-encompassing;
- It strives to inspire change and influence policy development process within the context where it exists;
-Shares first hand experiential information (memoirs) from the field about individual health care providers with the client in mind;
-Reflects on current standards of quality health care frameworks and models e.g. KQMH, KHPF among others;
-Provides crucial information, statements of facts and best practice standards drawn from elsewhere that might be applicable at the operational level/ point of service in Kenya;
-Introduces a comprehensive review of ***Best Care Anywhere Organizing Framework for Resource Constrained Settings*** (BCAOFR-CS) its application in interrogating quality of health care provision;

-Covers state-of-the-art, current affairs, topical & emerging Health Information Technology issues with a *future-today* approach with an eye for evidence based practice;

-Dissipates disillusionment with our health care system and instils health care workers with hope and encouragement about how they can make a difference;

- Exposes everything from trivia to mega that ails the health systems and structures in resource constrained settings.

-Apart from being scientific, it does not shy away from everyday communication: mass media, social media, politics, sociology of health, tagged news touching on health.

-In some way endeavours to make the challenges healthcare providers face visible to the person responsible and to whom it may concern. A good deal from the nursing angle.

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///ENDS///

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