

DECLARATION

I have not been presented for a degree in any other university.

**COMMUNITY PARTICIPATION IN HEALTH PRIORITY
SETTING IN MAGARINI DIVISION, COASTAL KENYA**

By

Joseph K. Mutai

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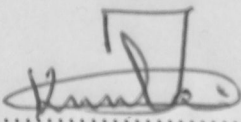
A Thesis submitted to the Institute of Anthropology, Gender and African Studies in fulfillment of the requirements for the Degree of Doctor of Philosophy in Anthropology of the University of Nairobi

Date: 11/11/13

2013

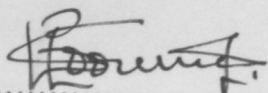
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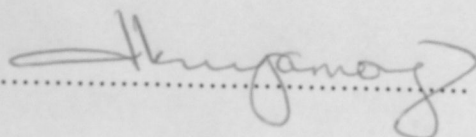
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This Thesis is dedicated to my grandparents, Agui Paul Mitei and the late ObotRecho, for their great dedication, constant mentorship, enthusiasm and support in ensuring that I go to school.

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My parents, Francis and Ruth Cheruiyot and my siblings for their continued encouragement and prayers during the entire period of my studies.

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I am also grateful and thankful to Dr W. Onyango-Ouma and Prof Isaac Nyamongo, my supervisors at the Institute of Anthropology, Gender and African Studies, for their support for my quest for further studies, comments and continued insights towards the realization of this thesis. My special gratitude also goes to the Kenya Medical Research Institute for its support in granting me time off and colleagues for their moral support throughout the study period.

Special thanks go to all my participants, informants and field assistant without whose contribution this work would not have materialized and to Catherine Waugari Njeru for her contribution in organizing transcripts.

Lastly, I am greatly indebted to my family, wife, Margaret Mutai and children, Carolyne Cheverich, Clara Chepkorir, Collins Kibet and Cynthia Chepkemot for their patience and understanding throughout the study period.

To you all I say thank you.

ACKNOWLEDGEMENTS

This thesis could not have been completed without the assistance of various people and institutions. First, I am greatly indebted to Dr Jens Byskov, DBL-Center for Health Research and Development, University of Copenhagen, Denmark for soliciting resources which enabled me to pursue my studies and his encouragement throughout the study period.

I am also grateful and thankful to Dr W. Onyango-Ouma and Prof Isaac Nyamongo, my supervisors at the Institute of Anthropology, Gender and African Studies, for their support for my quest for further studies, comments and continued insights towards the realization of this thesis. My special gratitude also goes to the Kenya Medical Research Institute for its support in granting me time off and colleagues for their moral support throughout the study period.

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Lastly, I am greatly indebted to my family, wife, Margaret Mutai and children, Carolyne Cherotich, Clara Chepkorir, Collins Kibet and Cynthia Chepkemoi for their patience and understanding throughout the study period.

To you all I say thank you.

ACRONYMS AND ABBREVIATIONS

AFR	Accountability for Reasonableness
AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organizations
CCH	Committee on Choices in Healthcare
CHWs	Community Health Workers
CDF	Constituency Development Fund
CISP	Christian Italian Support Program
DANIDA	Danish International Development Agency
DAP	Decentralization Action Plan
DHMB	District Health Management Board
DHMT	District Health Management Team
DHSF	District Health Stakeholder Forum
DFRD	District Focus for Rural Development
HIV	Human Immunodeficiency Virus
HPFP	Health Policy Framework Paper
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KMIS	Kenya Malaria Indicator Survey
KNBS	Kenya National Bureau of Statistics

MDDP	Malindi District Development Plan
MDHR	Malindi District Health Records
MSH	Management Sciences for Health
NASCOP	National AIDS Control Programme
NHSSP	National Health Sector Strategic Plan
NMS	National Malaria Strategy
PLWHA	People Living With HIV/AIDS
REACT	Response to Accountable priority setting for Trust in health systems
TBAs	Traditional Birth Attendants
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Program
WMS	Welfare and Monitoring Survey

ABSTRACT

This thesis focused on community participation in health priority setting in Magarini division, Coastal Kenya. The main objective was to explore community participation in health priority setting in Magarini division in Malindi district of Kilifi County. The study examined health priority setting processes in various institutions at the community level, community participation in health priority setting and factors that influence health priority setting at the community level in Magarini division.

The study design was a descriptive cross-sectional which utilized qualitative methods of data collection. Focus group discussions were conducted with twenty (20) participants from the various groups representing the community while key informant interviews were done with twenty nine (29) people comprising of health professionals, opinion leaders, health committees and program managers. The study participants were selected through convenient sampling.

Data from key informant interviews and focus group discussions records were transcribed, translated typed and exported to NVIVO software version 7 for processing and analysis using NVIVO tree nodes and sub nodes were developed based on the thematic areas identified from the research questions.

The findings suggested that health priority setting processes involved complex and difficult stages at the community level. There is a relatively low degree of community influence or control over organizations in which the community members participate and what the community members go through is an empty ritual of participation. The community has no

power to influence the outcome of any process indicating that the community is not actively involved in health priority setting and the overall decision making processes in the study area. Where the community is involved, the level of involvement and participation is vague. Comparatively, community participation in the activities of health development partners including priority setting in the study area was found to be high.

Health priority setting in the study area is characterized by passive involvement and participation of all the groups in the community as seen in the composition of the health committees from the district to the village level. Thus, the current health priority concerns do not carry the wishes and feelings of the majority of groups in the community. This is against the spirit and the overall goal of decentralization approach of incorporating community participation in determining own health priorities as stipulated in the health sector reforms introduced in 2005.

The study findings further showed that the health providers' attitudes and practices together with the socio-cultural issues, illiteracy, prevalence and burden of diseases such as HIV/AIDs, malaria, tuberculosis are the main factors influencing health priority setting and the general provision and utilization of health services in Magarini. Specific personal attitudes and practices of individual health workers and other staff are largely to blame for poor utilization of health services in many health facilities.

It is concluded that the community is a major stakeholder in health priority setting and its involvement and / or participation in health priority setting processes ultimately lead to maximum benefits. The study recommends that for effective health priorities to bear meaningful

results and impact positively in the provision of health services, the government and other stakeholders in health provision should recognize the contribution of the majority of the groups at the community level by giving them opportunities to participate in issues that they find most important to address their health needs. The Accountability for Reasonableness (AFR) is a useful framework for priority setting since fairness, trust and equity should be embraced to enhance community participation in health priority setting and thereby improved utilization of health services.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Priority setting is considered key to the sustainability of any health system. Due to weak economies especially in developing countries, systems in each country ends up making its own set of priorities regarding what it will provide (Martin, *et al.*, 2003). And because of the ever changing patient needs and the demands for health services outstrips available resources, priority setting is one of the most difficult issues faced not only by health institutions and communities but also health policy makers (Bell, *et al.*, 2004; Kapiriri, *et al.*, 2004). The socio-economic, political and technological changes occurring in the world have resulted in improved quality of life, population increase and lifestyle diseases, among other things, which have outstripped diminishing resources in many countries. In providing health services, most developing countries have had to grapple with issues of accessibility, affordability, availability and, overall, the quality of services. Governments have ended up creating inequalities in communities as they put into consideration issues such as class, gender, race, ethnicity, age or religious affiliation. These social divisions engender potential conflict, hostility, alienation and untold human suffering, as differing groups confront the effects of inequalities in political power, social status/prestige and economic rewards.

A study by Ham (1995) shows that understanding priority setting in health services in many developing countries is important for two main reasons. First, there is an increase in expenditure which is mainly funded from public resources and, two, the pressure this has exerted on governments which are trying to control public spending. Most countries face high demands on their health care systems and limited budgets to meet the demands. In many situations politicians want to get the highest value from limited budgets.

Priority setting is a more or less systematic approach to distributing the available resources among demands to fashion the best health care system possible, given the constraints. The criteria used in many developing countries is far away from the burden of diseases and even frequency of the diseases. Making priorities pertaining to allocation of resources in health in many developing countries is mainly based on political and / or tribal affiliations and is not evidenced based (Birch and Chambers, 1993; Wiseman, *et al.*, 2003). It therefore continues to be a politically charged topic in many developing countries. The underlying problem is that decisions on the choice of health interventions have been considered as complex and multifaceted (Kapiriri, *et al.*, 2006). Unfortunately, decision-makers in developing country health care institutions lack guidance with regard to priority setting and as a result priority setting occurs by chance and not by choice (Bryant and White, 1982; Steen, *et al.*, 2001).

Due to limited resources, the leadership in health care has to make hard choices about what services to fund and what not to fund. This process of priority setting has traditionally been shaped by organizational cultures where norms and incentives have implicitly supported historically-based resource allocation processes (Mitton and Donaldson, 2003). That is, in most health care organizations, the process underlying priority setting is based on the previous year's expenditure being rolled over to the current year, with some political and/or demographic adjustments. This can lead to allocation based on secret criteria and thus enabling politics to directly enter into the fray. The problem is that decision makers in various organizations across countries have expressed dissatisfaction with these processes, desiring more explicit, evidence based approaches to priority setting.

In Kenya, priority setting in health used to adopt the top-down approach with the Ministry of Health headquarters taking leadership in health care provision and policy making. Under health reforms such as National Health Sector Strategic Plan 1999-2003, the ministry has embraced decentralization programme, among other programs. This has seen the establishment of the District Health Management Boards and Health Management Teams to oversee the day-to-day management of the government health facilities at the district and health centre levels. The aim was to make priorities that reflect the needs and wishes of the community by involving them (Maina, 2004). In essence, this type of approach views the community as the beneficiary. The ministry realized that allocating scarce resources with a view to responding to ever increasing demands from the population especially at the community was a huge task, especially the demand for health care under conditions of extreme poverty and health needs (Stefanini, 1999). Because of the demand for health services that outstrips available resources, some form of priority setting must occur. This is one of the difficult tasks faced by health leadership (Gibson, *et al.*, 2005; Kipiriri, *et al.*, 2009).

Though the decentralization program aimed at making many stakeholders at the community level participate in decision making processes with a view to arriving at an increased acceptance and sustainable outcomes as well as to encourage local initiatives, it lacks the sensitization element that is essential in bringing out health concerns of the population. In December 1989, for instance, the Ministry of Health introduced a cost-sharing programme which ran into problems with the community as far as affordability is concerned and was suspended in September 1990 (Collins, *et al.*, 1996; Owino and Abagi, 2000). Rising medical costs imposed difficult health choices for individuals, families and the communities. This is

because few resources exist especially in rural areas to provide emotional and educational support during the process of making difficult health decisions.

Following the failure in sustaining programs within the community under the top-down initiative, attempts have been made to involve the community and make them participate in activities under the bottom-up approach. In this effort, participatory approaches aimed at making communities own and manage programs have therefore been advanced, though varying from development agency to the other. Community participation means that there is some form of involvement of the people, at the grass-root level, with common needs and goals in decisions affecting their lives. The assumption in this perspective is that communities in rural areas are always organized and cohesive.

Community participation in any rural development has been recognized as a basic operational principle of rural development (Chifamba, 2013). Studies (such as Daniels and Sabin, 2002 and Goldman, 2004) have supported the idea of involving the community in setting health care priorities. As far as public funds are concerned, the community is the most important stakeholder of the healthcare system. Based on that, legitimacy and fairness demand that they be at the priority-setting table; that this is a way of keeping with the principles of democracy; that empowering people to provide input in decisions that affect their lives encourages support for those decisions, which in turn improves the community's trust and confidence in the health care system (Traulsen and Almarsdottir, 2005).

Community participation does not replace but enhances the formal decision-making functions. In addition public involvement provides a crucial perspective about the values and priorities of the community, which should lead to higher quality, or at least greater acceptance of

priority-setting decisions (Ham, 1993). While community participation may eventually bring many lasting benefits to all groups of people it can be an opportunity to take over power and control of issues with a view to redistributing power that enables especially the vulnerable groups to deliberately be included in priorities.

Other studies have shown that making the public to participate at the community level in setting priorities (especially health and health care priorities) is a constant challenge for health system decision makers at all levels as other competing issues struggle for attention (Abelson, *et al.*, 2003; Penelope, 1999), on the one hand, and leadership issues, powerlessness and poverty, among others, on the other hand (Chambers, 1983).

1.2 Problem Statement

All health care systems in developing countries like Kenya face problems of justice and efficiency related to setting priorities for allocating a limited pool of resources to a population. This makes it difficult to provide everyone with the required services. Scarcity raises questions of justice and efficiency mainly on how limited health care resources may be allocated to the community. Even the meagre resources available are embezzled or mismanaged by leaders and policy makers whose knowledge and understanding on priority setting is low.

The establishment of the District Health Management Boards and Health Management Teams / committees in Kenya was meant to coordinate the general management of the government health facilities at the district and dispensary centres levels. This was a deliberate effort towards incorporating the needs, views and wishes of the majority of the stakeholders at the community level with a view to participating in health priority setting. However, instead of

giving the community an opportunity to contribute local initiatives which will be acceptable and sustainable, the health teams/committees are implementing government priorities ignoring the community's views and priorities which are the pillars in any health care system. There is a huge demand for health care services at the community level that exceeds available resources at that level. The priorities of the community concentrate around the effects of poverty, hunger, drought and diseases such as cancer, tuberculosis, malaria and HIV/AIDS. These pose serious challenges both to community resources and leadership.

Resource allocation and other priorities in health done at the national level have depended on historical or political affiliations and are not based on the burden of disease or other relevant criteria or values. Several reforms that have been proposed and/or implemented at the community level have failed to yield the anticipated results largely because the community has not been involved at all the stages for their values and feelings as primary consumers of services. Community participation and involvement in all aspects of priority setting is never meant to out-rightly replace formal decision-making but to enhance the same. The whole concept is basically to recognize, consider and use the input of the community to make better and more sustainable decisions. However, the leadership has taken advantage of ignorance, limited organisational and managerial skills and powerlessness that exist at the community level to appoint people of their own choice to represent the community. This makes committees at the community level vulnerable and can be easily manipulated to represent appointing leader's personal views and not the community's. This raises questions of equity, access and fairness.

Due to lack of mechanisms of communicating health priorities of the community to the health committees and lack of appeal mechanisms, representation in the committees is to take care of the interest of individuals, thus the views of the community are not necessarily represented. This has resulted in priorities that are not relevant to the felt needs and wishes of the community. The existence of inequalities in health is an indication that the existing priorities were not done based on community priorities. A big proportion of the population at the community level including people with disabilities, women, men, youth, old and elderly are often left out and their needs not taken care of whenever health priorities are determined, making the priorities unfair to them. Health priorities have therefore ignored fairness by not giving the community a chance to participate and contribute, which is one of the goals of priority setting in as far as the distribution of resources is concerned. Fairness ensures that health priority setting at the community level is relevant to users (community). The community need to be informed of the process of priority setting through publicity mechanisms and need to be able to amend / appeal if they are not satisfied. This study sought to investigate community participation in health priority setting in Magarini division by answering the following research questions:

1. What are the processes involved in health priority setting at the community level in Magarini division?
2. What is the level of community participation in priority setting in health priority setting in Magarini division?
3. What are the factors that influence health priority setting at the community level in Magarini division?

1.3.0 Study Objectives

1.3.1 General Objective

To explore community participation in health priority setting in Magarini division, Kenya

1.3.2 Specific Objectives

1. To assess health priority setting processes at the community level in Magarini division
2. To determine the level of community participation in health priority setting in Magarini division
3. To establish factors that influence health priority setting at the community level in Magarini division

1.4 Justification

Demand for health care services in developing countries like Kenya threaten healthcare systems if priorities between competing needs and demands are not agreed with the population especially at the community level. Decision makers at the national levels struggle to ensure that priority setting in set-ups within the community are made with a view to ensuring that the limited resources available at the community level are distributed equally and fairly based on the demands of each category of the population. For sustainability of health programmes at the level, decision makers have had to develop and implement policies that are geared towards incorporating all the stakeholders in health into contributing to health priority setting at the community level. One approach of understanding how priority setting is done at the community level was to explore community participation in health priority setting.

Non participation of the community in health priority setting is a threat to health policies and priorities because the community are the outright consumers of services and the many health policies developed by the relevant stakeholders and thus have detrimental effects on sustainable development if not given the attention it deserve. In spite of that, community participation especially in poor resource settings where the majority of the populations reside has not been adequately researched on, yet it is the strength of these that policies and programmes are formulated.

The findings of this study will provide a better understanding of health priority setting processes, the circumstances under which priorities are arrived at in difficult situations where resources are not available and the general factors that influence priority setting at the community level. The study findings will go a long way in informing policy makers of the need and importance of developing feasible programmes that incorporate views, needs and wishes of the community. Health providers will eventually be able to better contextualize issues facing the populations at the community level.

There is need for a rational, all inclusive and transparent approach to health priority setting that guides policy makers and other stakeholders in their choice of health interventions that maximizes social welfare. Instead of concentrating on single criteria, policy makers need to make choices taking into account multiple criteria simultaneously. Making the community participate in priority setting processes in health will go a long way in creating a workable and sustainable implementation processes.

It is anticipated that the findings and conclusions that have emanated from this study will be useful in enhancing and empowering community participation in health priority setting at the community level. This will result in programs which are geared towards alleviating the suffering of the community.

1.5 Scope and Limitations of the Study

This study was anthropological in approach as it emphasis was on the field of cultural / social anthropology. This study focused on community participation and the factors influencing health priority setting in social and health structures within the community from Malindi district through Magarini division up-to the village level as a way of understating how health priority settings are done and how priorities in each of the levels draw its priorities from each other. The study further focused on the participation and overall contribution of the various groups in the community, on the one hand, such as women, people with disabilities, youth and the old and the elderly and the small communities under the Giriama like the Waata and Kauma. There was no attempt to push this study to other domains where there was a direct link to other domains. For instance, no political investigations were carried out to determine the selection/appointment of certain people to the health committees at the various levels in the community.

Participants were assured of confidentiality of the information they were giving particularly when some of the information sought was sensitive. Tracing some participants especially in the community was another limitation to the study. This was because some of them did not have contacts. In such instances, chiefs were sent well in advance to inform them to meet the author on a date and time proposed by them. The accountability for reasonableness (AFR) which the study has applied as its theoretical framework specifies a number of

requirements/requirements (publicity, appeal/revision, relevance and enforcement/leadership) for the organizational structures of priority setting in health care settings. The framework provides limited guidance on ways in which the conditions of the framework should be implemented so as to achieve fair and legitimate priority setting.

2.7 Health Priority Setting

Existing literature in health priority setting describes priority setting in various health care contexts both at the national and community levels. According to Cookson and Dolan (2000) and Kishor, et al., (2003) they are decision-making principles and approaches that are typically used in setting priorities. But most developing countries face high demands on their health care systems and limited budgets that go a long way in meeting the demands. The demand for health services together with the ever changing patient needs have been shown to exceed the available resources thus making priority setting in developing countries one of the biggest challenges faced by health institutions, communities and health policy makers (Dell, et al., 2006; Gibson, et al., 2005). Arising from that, countries facing lots of challenges / weaknesses in their health systems and each system have ended up making their own sets of policies regarding what they will provide. The situation is further aggravated by series of challenges / constraints / issues that compete for attention in many developing countries. Choosing between these competing values / issues makes priority setting fundamentally an ethical issue (Hager and Mays, 1998).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this Chapter, literature pertaining to the study topic is reviewed with a view to providing an understanding of health priority setting at the community level, especially the participation of the community in health priority setting. The theoretical framework and the conceptual model that guided the study are also described including the operational definitions of variables used.

2.2 Health Priority Setting

Existing literature in health priority setting describes priority setting in various health care contexts both at the national and community levels. According to Cookson and Dolan (2000) and Kapiriri, *et al.*, (2003) there are decision-making principles and approaches that are normally used in setting priorities. But most developing countries face high demands on their health care systems and limited budgets that go a long way in meeting the demands. The demand for health services together with the ever changing patient needs have been shown to overstretch available resources thus making priority setting in developing countries one of the biggest challenges faced by health institutions, communities and health policy makers (Bell, *et al.*, 2004; Gibson, *et al.*, 2005). Arising from that, countries facing lots of challenges / constraints in their health systems and each system have ended up making their own sets of priorities regarding what they will provide. The situation is further aggravated by series of challenges / constraints / issues that competes for attention in many developing countries. Choosing between those competing values / issues makes priority setting fundamentally an ethical issue (Singer and Mapa, 1998).

As a result of limited resources, the criteria used in many developing countries as far as priority setting is concerned have been shown to be far away from the burden of diseases and even frequency of the same. Priority setting has been argued to involve value-laden choices, which are more technical. Eventually, the approaches ends up not providing the necessary skills to decision-makers with a view to enabling them address a broader range of relevant values such as trust, equity, accountability and fairness (Byskov, *et al.*, 2009).

But the variations between the levels of priority setting may not be surprising, given that different levels involve different actors with different roles and concerns. The actors at the different levels also make different kinds of priorities, which may affect their perception of fairness. However, since actors at the different levels have varying roles and concerns and are influenced by the political culture and institutional framework within their organizations it can be deduced that the different actors' perceptions of fairness in priority setting would vary according to their level of decision making and their political and institutional contexts (Kapiriri and Martin, 2007).

The health inequalities seen in many developing countries could be a consequence of sub-optimal use of the limited resources in the community as far as equity and affordability are concerned. Indeed, one of the goals of priority setting and decision making is fairness in terms of the distribution of resources, considered a key element when health care resources are scarce. A fair process involves consistent use of set rules, guidelines and procedures and is one with definite procedures and structures, which should be used consistently so as to reduce the impact (Kapiriri, *et al.*, 2007).

Making priorities pertaining to allocation of resources in health in many developing countries are mainly based on political and or tribal affiliations and not evidenced based (Birch and Chambers, 1993; Wiseman, *et al.*, 2003). It continues to be a politically charged topic in many developing countries. Understanding the meaning and art of deciding is considered to be the most important task of leaders and therefore paramount (Garvin and Michael, 2001). The underlying problem is that decisions on the choice of health interventions are complex and multifaceted (Kipiriri and Norheim, 2004) and the process is therefore ad-hoc or history-based. Unfortunately, decision-makers in health care institutions lack guidance with regard to priority setting and as a result priority setting occurs by chance and not by choice (Steen, *et al.*, 2001).

Priority setting prioritizes provision of basic necessary health care, doing the best within the given resources and prospective planning. Setting priorities in health care means allocating limited resources so that some programs are supported and others are not. Indeed, distribution of resources among competing programs or people occurs at all levels of health care system and has been identified as the main important issue in health care management (Martin and Singer, 2003; Mckneally, *et al.*, 1997). Health expenditures in many developing countries are often focused on services for richer areas or groups at the expense of the poor, even where the latter offers greater scope for cost-effective healthcare. Also, policy makers may follow funding preferences of (international) organisations, which may not always be in line with national priorities (Goddard, *et al.*, 2006; Ollila, 2005).

Priority setting, in governance, involves redistribution of decision making power and authority between the headquarters and its branches spread out in the country. There exist a strong tradition of centralized planning and administrative control in Africa. Decentralization,

a system that has been embraced by many governments as an aspect of leadership, is a deliberate effort to making priorities and decisions that carries the needs and wishes of the local people by involving them. The system has been to strengthen the capacity of the branches at the lower levels to deliver services to its population. Thus, priority setting is the ability to make decisions and set priorities and, at the same time, how to share responsibilities between the centre and lower-levels of an organization.

2.2.1 Decentralization of Health Services

The World Health Organization proposed decentralization as a way to empower communities to take ownership and control of their own health in 1978. The approach has therefore been adopted by many developing countries as a key management approach on the belief that it enhances efficiency in public sector performance.

Decentralization, an aspect of leadership that has been adopted by many governments in all sectors, is a deliberate effort to make policies and programs reflect the needs and wishes of the local people by involving them, thus making development plans realistic and easy for adoption. According to the World Bank, decentralized delivery is based on the simple concept of getting resources to where they are needed (World Bank, 2000). A study by Maina (2004) has shown that the main aim of the decentralization has been to strengthen the capacity of local authorities to deliver services to its residents. Taking services closer to the people would make it more responsive and more likely to develop policies and outputs, which meet the needs of ordinary population. However, the most commonly used definition of decentralization is the transfer of decision-making power and administrative responsibility from central governments to the periphery (Bossert, 1998). The range of decision-making

powers involved covers fiscal allocation, public planning, service delivery and systems management.

In Kenya, health priority setting has for a long time adopted the top-down approach. Priority setting processes rested with the Ministry of Health headquarters taking leadership in health care provision and policy making. Following the publishing of the *National Guidelines for the Implementation of Primary Health Care in Kenya* in the year 2000 the stage was set for the start of improved health care delivery with the emphasis on 'decentralization, community participation and inter-sectoral collaboration. In order to enhance provision of quality health care which is acceptable, affordable and accessible to all the populations some policies such as The Kenya Health Policy Framework Policy Paper (1994-2010), the National Health Sector Strategic Plan (NHSSP) 1999-2004 I and II 2005-2010 were introduced (GoK, 1999).

Following the Kenya's Ministry of Health's commitment to decentralization of the health care delivery through redistribution of health services to rural areas as reiterated in the policy documents, the health sector has evidenced many changes in the restructuring process. The policies have mandated District Health Management Boards (DHMB) and Health Management Teams (DHMT) to oversee the day-to-day management of the government health facilities at the district and dispensary levels.

The underlying factor for the above has been to take the community needs, interests and values with a view to making them own and eventually have a say in making decisions and setting priorities. Such a move was intended to provide the actors influence over decision-making and priority setting which was going along way in reducing the problems of lack of

credible commitment and in turn strengthen the desire to promote efficiency and equity as health service principles for priority setting (Mooney, 2005).

In trying to provide services, governments have ended up creating inequalities in communities as they put into considerations issues such as class, gender, race ethnicity, age or religious affiliation. These social divisions engender potential conflict, hostility, alienation and untold human suffering, as differing groups confront the effects of inequalities in political power, social status/prestige and economic rewards. This may explain the fact, for instance, that the distribution of illness in society is seen to follow closely the distribution of income and wealth (that the level of income determines to a great extent standards of housing, type of local environment and other factors such as diet, clothing and overall quality of life). This has witnessed socially marginalized communities that have continued to face constraints in accessing and affording health services. These are the core elements in any system of stratification, dramatically affecting the well-being and development of communities.

According to Blane (1985) health inequalities influence social mobility, the healthy tending to be upwardly mobile, while the unhealthy drift downwards. The material explanation emphasizes the importance of differences in material constraints, such as living and working conditions throughout communities. Blane further suggests that this is the only way to account for the overall improvement in the health of the population, at the same time as social class differences are maintained. According to this approach, income distribution, poverty, access to education, housing or working conditions are seen as contributory, causal factors.

Arising from the above, decentralization is seen as the redistribution of decision-making and priority setting responsibility between the centre and lower-levels of an organization (Chweya, 2006). In governance, it involves redistribution of decision making power and authority that goes with it between the headquarters and the field units such as districts, provinces, regions or local councils.

2.2.2 Accessing and Financing Healthcare Services

In trying to provide health services, most of the developing countries have had to grapple with issues of accessibility, affordability, availability and, overall, the quality of services (World Bank, 1987).

Health sector reforms were introduced under the umbrella of Structural Adjustment Programmes (SAPs) implemented in the 1980s, necessitated by the debt crisis. The economic crisis was evident in the diminishing financial abilities of government to provide social services such as health and education. With or without SAPs, African governments were faced with the challenge of sourcing funds in order to continue financing social service provisioning. One of the ways of sourcing funds was located in the potential to pay by users, hence the introduction of cost sharing.

Some developing countries commenced discussions about priorities for health care and concentrated on priority setting in health services for two main reasons. Firstly, there is an increase in expenditure which is mainly funded from public resources and, secondly, the pressure this has exerted on governments which are trying to control public spending (Ham, 1995). These efforts took different forms: all included health care experts, but they differed in inclusion of government officials and public representatives and in the details of the frameworks they outlined.

The Government of Kenya committed to providing free health services for all citizens in 1963 as part of its development strategy towards improving the welfare and productivity of its population. The government envisaged that a full range of heavily subsidized health and education services will be available to all the citizens (Owino and Abagi, 2000). Kenyans, though, continued to be overburdened by the out-of-pocket health financing which has been identified as a major barrier towards accessing health care (MoH, 2006). The onset of socio-economic crises witnessed in the late 1980s proved to be a major blow to the government commitment to providing free health services.

Arising from lack of sufficient resources, the Government of Kenya has been struggling to deal with the dilemma of combating a growing burden of disease, regulating quality and improving equity in health care distribution within the context of declining public financing that is forcing rationalization of health service delivery. The government, as reflected in the various reforms such as National Health Sector Strategic Plan 1999-2003, has shown its commitment to creating an enabling environment for the provision of sustainable quality health care which is acceptable, affordable and accessible to all Kenyans.

Since independence, Kenya has had a predominantly tax-funded health system (it spends 5.1% of its gross domestic product on health), but gradually introduced series of health financing changes. In 1989, user fees, or 'cost sharing' were introduced (Dahlgren, 1991). User fees got into affordability related issues by the intended consumers and were suspended in September 1990 but re-introduced in 1992 because of budgetary constraints. The user fee system was significantly altered in June 2004 when the Ministry of Health stipulated that health care at dispensary and health centre level is free for all citizens, except for a minimum registration fee in government health facilities (Carin, *et al.*, 2007).

Removing user fees in primary health care services is considered one of the critical policy issues being considered in many developing countries (Chuma, *et al.*, 2009). Proponents of user fees noted that fees would generate additional revenue, which could be used to improve equity and efficiency; that graduated fees would encourage use of low cost primary health care services rather than expensive referral facilities; and that they would improve targeting of resources by reducing unnecessary demand (World Bank, 1987). A study on user fees has further shown that user fees impact negatively on the demand for health care, contribute towards household poverty, promote inequalities and generate little revenue (Mbugua, *et al.*, 1995; Mwabu, *et al.*, 1995).

The main dilemma in health care finance has been allocation according to need and defining the 'need' of the population has been a major bottleneck in many developing countries. Indeed, these are the methods used to distribute national funds to regions and other geographical areas (Rice and Smith, 2001) which, should entail distributing funds on the basis of existing national average expenditure, given certain socio-demographic characteristics of individuals (such as age, gender, and disability status, among other factors). This not only raises issues relating to fairness but also equity. Culyer and Wagstaff (1993) qualify that equalizing the distribution of health is not to be achieved by deliberately reducing the health of some members of society but by an increase in expenditure.

2.3 Community Participation in Health Priority Setting

The decentralization program aimed at making all the stakeholders (including the community) at the lowest levels to participate with a view to arriving at an increased acceptance and sustainable outcomes as well as to encourage local initiatives. Participation includes people's involvement in decision-making processes in implementation programmes, their sharing in

the benefits of development programmes and their participation in efforts to evaluate such programmes (Collins, *et al.*, 1996; Oakley and Mardsen, 1984).

Involving the community in as far as priority setting processes are concerned has not been easy due, partly, to leadership styles employed by leaders. Majority of the communities are poor, illiterate or semi-literate and have been termed as being not well organized with no political muscle. Chambers (1983) noted:

Poor people are rarely met (consulted). When they are met, they often do not speak. When they do speak, they are often cautious and deferential, and what they say is often either not listened or brushed aside, or interpreted in a bad light (p18).

Bergdall (1993) noted that there is an atmosphere of passivity and dependence prevailing in rural communities. In that sense, people have become accustomed to petitioning those in authority, or donors with outside resources to do something on their behalf. This, therefore, reinforces a self-perception of themselves as submissive objects of development rather than active players.

According to Abelson, *et al.*, (2003) and Penelope (1999) involving and making the public or community participate in setting priorities especially health and health care priorities are a constant challenge for health system decision makers at all levels (local, regional and national) of government as other competing issues struggle for attention under circumstances mentioned above. But the prospects for credible commitment by the community are greater in that they, as a community, will normally be around longer than the decision makers or the elected politicians. Thus bringing in the community and their values gives these actors influence over decision making which will decrease the problems of lack of credible commitment and in turn strengthen the desire to promote efficiency and equity as health

service principles for priority setting (Avineri and de-shalit, 1992). The underlying factor has been to take the community to own and eventually have a say in making priorities and subsequently have the overall control of the processes. Such a move is intended to provide the community influence over priority setting which will go a long way in reducing the problems of lack of credible commitment and in turn strengthen the desire to promote efficiency and equity as health service principles for priority setting (Mooney, 2005).

While explaining the bottom-up development approach, Bhatnagar and Williams (1992), describes participation as a process by which people, especially disadvantaged, influence decisions that affect them. Participation is viewed not simply to mean involvement but also to mean influence on development decisions in as far as the processes of priority setting and decision making are concerned. The group referred to as disadvantaged are people who are materially poor, people with no access to social amenities such as education and health, minority ethnic groups and victims of gender discrimination. With this, participation is viewed as incomplete without the dimension of empowerment which is an objective of popular participation.

Cernea (1992) further suggest that participation in itself does not adequately address the issue of ownership of local initiatives. The argument is that people who take control of their own lives by making own choices and priorities, planning, implementing and making judgement on the project's success or failure cannot be said to have participated. And that they are the actors and managers of their own economic growth, survival and change programs. But according to Munguti (1989) and Mulwa (2008) the community can participate in programs in many ways including offering 'free labour'. It is in that aspect that many implementers of programmes have reported high levels of participation.

Daniels, *et al.*, (2002) and Goldman (2004) have rooted for the idea of involving the community in setting health care priorities. This is mainly because citizens are the most important stakeholders of the health care system. In that regard, legitimacy and fairness demand that the community be at the priority-setting table as a way of keeping with the basic principles of democracy. Empowering people to provide input in decisions that affect their lives encourages support for those decisions, which in turn improves the public's trust and confidence in the health care system (Traulsen and Almarsdottir, 2005). In addition, the community involvement and participation provides a crucial perspective about the values and priorities of the community, which should lead to higher quality, or at least greater acceptance of, priority-setting decisions.

2.4 Barriers to Community Participation

According to Knox and McAlister (1995) the community is not informed well enough about the complicated scientific, clinical and administrative aspects of health care to contribute meaningfully to priority setting. However, many members of the community have real-life experience as users of the health care system and other public services (such as education) and can offer insight into the values and beliefs of the public at large. In genuine community engagement, members are not expected to be scientific experts, but rather to provide their perspectives (Daniels and Sabin, 2002).

According to Turnbull and Aucoin (2006) priority setting has for sometime been framed as a technical exercise focusing on evidence-based medicine and cost-effectiveness analysis. In that situation members of the public would be reluctant to participate in such technical discussions for which they are not equipped. In addition, too often members of the community

who have been "consulted" about policy choices later find that their views have been ignored, which leads them to conclude that their input was not valued, thus causing anger and cynicism.

Members of the community often perceive an intimidating power imbalance between them and clinicians and policy-making experts, which can undermine the legitimacy and fairness of the priority-setting process. Efforts have not been made with regard to minimizing the differences by setting an appropriate time during deliberations and including a sufficient number of representatives of the community on decision-making bodies so that they do not feel that their membership is viewed as a token (Gibson, *et al.*, 2005). In circumstances where there is a commitment to meaningful community involvement, very few members are involved. This may be too few for a critical mass and reduces the probability of reflecting the broad views of the public (Martin and Singer, 2003).

Another barrier to community engagement is the concern that those chosen will not be representative of the public. A small number of community representatives on a decision-making committee cannot possibly represent all legitimate public views. However, the same can be said of the ability of a small number of clinicians or health care managers to represent the complexities of their constituencies' views, much less the views of the community. What is important is not that those individuals represent all sectors of their communities, but that a diverse group of fair-minded individuals from relevant constituencies come to the table, participate in deliberations and articulate a range of diverse and relevant values (Daniels and Sabin, 2002).

People's right to participate in community affairs is hampered by high levels of poverty, illiteracy levels, lack of untapped resources and other developments (Chambers, 1983). People wielding socio-economic and political power have their ideas largely forming part of priorities.

Finally, involving the community will make the decision-making process too protracted (Lenaghan, 1999). Some methods of community involvement, such as having members on decision-making committees, typically have little impact on the time required to make a decision. The other method, such as consulting with the community through public forums, is viewed as an extension of the time required.

2.5 Leadership in Priority Setting at the Community Level

In the traditional African communities, leadership emerged on the basis of a popular consensus and was not imposed. People used to make their support known through open and tacit approval of the way the leaders conducted the affairs of the people. In the instances where people disapproved of the leadership or certain decisions, they tended to vote with their feet and moved to other areas and communities where they could establish an acceptable form of leadership. The colonial rule disrupted the traditional forms of governance and shook the foundations on which African nations had been based for thousands of years introducing its own administration, political systems and culture (Ochola, 2007).

Leadership has been shown to carry a heavy burden of responsibility but it can be exciting and stimulating at the same time. Priority setting is one of the reasons making leadership a major challenge and one of the easiest to get wrong (D'Souza, 2007; Garvin and Michael,

2001). The belief is that many people treat priority setting as an event, a discrete choice that takes place in a single moment. Leadership involves identifying priorities and being able to make decisions.

Leadership involves understanding the needs, interests, values and aspirations of others which makes it a delicate balancing act with self-interest, values and aspirations. Leadership requires sober minds as the process of deciding involves making alternatives with a view to getting the "best" or "right", the fear of making wrong decisions and fear of judgment by others (D'Souza, 2007). This means that caution should prevail throughout leadership as often alternatives that may be better may be eliminated in the process and also requires a considerable amount of data analysis, listening and reflection. Arising from this has been the general belief and difficulty in life of many people in making the choice and treating decision making as an event, a discrete choice that takes place in a single moment.

Involving people, stakeholders and community is not a sign of weakness but a foresight and a sense of direction which is an important milestone in leadership. It gives them the influence over decision making which decreases the problem of lack of credible commitment and in turn strengthen the desire to promote efficiency (Mooney, 2005). More-often, popular participation in development, a process by which people especially disadvantaged influence decisions that affect them, is broadly understood as the active involvement of people in the priority setting process in so far as it affects them (Bhatnagar and Williams, 1992; Oakley and Mardsen, 1984). A strategic leader can utilize decision-making teams as a powerful asset in successfully coping with the environment. Such teams improve their decision making by using a process of consensus, a process useful when developing policies or opinions both in

public and private sectors. Knowing how to forge consensus for policy development and implementation is critical to successful management and leadership.

Leadership in health care is about facilitating evidence-based practice and improving patient outcomes through quality care. Therefore, if leadership is defined as a largely remote 'managerial' phenomenon, involving decision-making and influence from a distance, and/or is invested with absolute and all-embracing power and authority then it is clear that egos rather than issues may come into play (Millward, 2005). Leadership in health care is not about egos, it is about effective delivery of health care at the front line.

In addition, leadership is seen in the ability of the headquarters as far as the redistribution of decision-making and priority setting responsibility between the centre and lower-levels of an organization is concerned. It also involves redistribution of decision making power and authority that goes with it between the headquarters and the field units such as districts, provinces, regions or local councils.

Though successful priority setting is a desirable goal for decision makers, priority setting has become one of the biggest challenges faced by health decision-makers worldwide. Hospital administrators, constrained by budget restrictions and confronted by increasing demand, find it a particularly difficult challenge to maintain services and quality, while controlling costs; decision makers (or leaders) lack guidance and information for priority setting and are unaware of priority setting tools available to them (Gibson, *et al.*, 2005).

According to Mitton and Donaldson (2002) decision makers were "frustrated with the lack of an explicit priority setting framework" and questioned "the credibility of resource allocation decision-making". Several studies have reported that leaders desire an explicit framework to guide priority setting (Mitton and Prout, 2004; Teng, *et al.*, 2007) and acknowledged leadership as a key area where improvement can make the most difference (Reeleder, *et al.*, 2005). The sustainability of healthcare systems worldwide is threatened by a growing demand for services and expensive innovative technologies. Decision makers struggle in this environment to set priorities appropriately, particularly because they lack consensus about which values should guide their decisions (Holm, 1998).

According to Lomas, *et al.*, (1997) and Mitton and Donaldson (2002) priority setting within health institutions may require assistance on how to make and deal with priority setting. Indeed, it is clear that, at least in some jurisdictions, measuring the 'return on investment' and planning for how resources should best be spent are not always very far advanced. But local people's knowledge in the form of beliefs and practices on all issues touching on their lives have been underrated and therefore seen to be backwardness to outsiders – though this is sometimes harmful according to the values of the local people themselves (Chambers, 1983).

The sustainability of healthcare systems worldwide is threatened by a growing demand for services and expensive innovative technologies. Decision makers struggle in this environment to set priorities appropriately, particularly because they lack consensus about which values should guide their decisions. One way to approach this problem, as suggested by Sibbald, *et al.*, (2009) is to determine what all relevant stakeholders understand successful priority setting to mean. Countries differ in respect of the range of available treatments and health care

facilities. This may be due to differences in the overall level of health care funding or to differences in the way these funds are allocated among competing uses or both.

While recognizing that the community views are important in health priority setting, the literature review shows that priority setting is complex, difficult and contentious (Wiseman, *et al.*, 2003). And in getting priorities from the community, the approach for getting the health priorities largely depends on the issues at hand but there is no standard methodology for the same. Some approaches can be very technical in nature that the relevance of the community is lost. In the face of this complexity, there are increasing demands from governments and healthcare funders for more formalized, workable and transparent approaches to health priority setting.

2.6 Theoretical Framework

This study used the accountability for reasonableness (AFR) as its theoretical framework. It is a framework which has been used as an analytical lens to facilitate social learning in as far as priority setting is concerned and also connect priority setting to broader, more fundamental democratic, deliberative processes that have an impact on social justice (Martin and Singer, 2003). It is a framework for legitimate and fair priority setting that is grounded in justice theories that emphasize democratic deliberation (Cohen, 1994; Olsen, 1997; Olsen and Rogers, 1991). For this reason it is able to provide guidance for the 'democratization' of priority setting processes. Justice is rooted in fairness and AFR holds that people are not entitled to the same set of services but, rather, to determinations made through fair procedures. It is a framework in priority setting that has been developed and tested for application in a range of organizations and settings such as in both resource-endowed and

resource-constrained health systems (Daniels and Sabin, 2002; Martin, *et al.*, 2003; Kafiriri and Martin, 2007; Maluka, *et al.*, 2009 and Bukachi, *et al.*, 2013).

According to the framework, health care systems engaged in priority setting have a claim to fairness, a common priority setting goal in every healthcare system, if they satisfy four conditions; relevance, publicity, appeal and enforcement/leadership which are grounded in the theories of justice (Daniels and Sabin, 2002; 2008).

Firstly, relevance is where priorities are arrived at on the basis of reason like evidence or principles and that the priorities reflect the wishes and the feelings of the community. This study found that most of the health priorities identified at the community-based organizations and the structures in the public health sector were all relevant to the needs and wishes of the community. The worry which was found by this study was on actualization of the priorities identified. Resources for the realizations of the priorities identified were noted to be with the government and the community-based organizations themselves and not by the community which were found to be the last to decide on which priorities to be implemented.

Secondly, the priorities and their rationales should be transparent and made publicly accessible to all the stakeholders. This is where after deliberating on the various options/priorities identified, justifications for whichever option agreed upon should be clear and agreeable to the community. In many instances, this study found that the manner in which health priorities were made in the various health committees was not transparent as the agenda in various stages where the community was involved. Justifications for whichever priorities arrived at were not clear either as community representatives in the various structures were not able (not empowered) to demand for the same and or that the leaders were deliberately

pushing their agenda and therefore decided not to divulge their rationales for choice of priorities.

Thirdly, revision means that there should be opportunities and or avenues to revisit and revise priorities in light of further evidence or arguments, and there should be a mechanism for challenge and dispute resolution. As discussed in Chapter Four, this study found that the community was getting opportunities to revise their health priorities mainly in the Non-governmental organizations unlike in the public facility levels.

Lastly, the leadership/enforcement ensures that the first three conditions are actualized. This study found that the community through their representatives either at the NGO or at the various committee levels did not have mechanisms of ensuring that their priorities are implemented. It is the NGOs and the leadership of the committees that were found to be involved in the ranking and final decision on the priorities to be implemented. Ranking allows positioning the selected priority issues in 'ascending' or 'descending' order of importance, in relation to specific (predefined) criteria. While ranking the identified health priorities, transparency and inclusiveness need to be ensured.

AFR has been applied in a number of studies in Tanzania, Canada, Norway, United Kingdom and elsewhere, the results of which have demonstrated that decision-makers, as well as health care providers, consider it an acceptable and reasonable approach (Gibson, *et al.*, 2005; Martin, *et al.*, 2003; Maluka, *et al.*, 2009). With the exception of the studies in Tanzania and Uganda (Kapiriri and Martin, 2007; Kapiriri, *et al.*, 2009) studies that evaluate the fairness and legitimacy of priority-setting through use of the AFR framework in low-income countries are scarce.

AFR provides structure to the process of priority setting that helps leaders to establish priorities within their specific contexts, while taking into account the available resources and regulatory conditions. The resultant priorities therefore have better chance of gaining acceptance and support, leading to sustainable health action and improved health outcomes (Martin, *et al.*, 2003). AFR based improvement of priority setting can be accommodated in any planning and management procedures from strategic level to facility operations. The focus on the process of priority setting rather than on the priorities as such is an innovation that responds to the long standing calls for increased focus on process and context to enhance the delivery of quality service. AFR provides a framework for such focus, hence it becomes an important reference for priority setting (Gruskin and Daniels, 2008) and has been assessed and in various degrees and forms been incorporated in health services settings in several countries including Canada, United Kingdom, New Zealand, Sweden and the USA as well as in more resource poor settings such as Mexico (Daniels and Sabin, 2008), Zimbabwe (Mielke 2003), Uganda (Kpiriri, *et al.*, 2009) and Tanzania (Maluka, *et al.*, 2009; Mshana, *et al.*, 2007).

2.7 Relevance of the Framework to the Study

AFR helps to operationalize the concept of fairness in different contexts. Traditionally, patients and members of the public, and in particular members of marginalized groups, have been excluded from important priority setting decision making, even in contexts where these decisions have a significant impact on these groups' well-being. AFR meets the conditions for fairness by providing a justification for including these groups in priority setting decision making and also provides practical guidance for decision makers on how to enhance the inclusiveness of their priority setting decision making. This makes the implementation of the

process smoother. The AFR demonstrate that the four conditions are recognizable and applicable across health care systems and levels of priority setting (Kapiriri, *et al.*, 2009).

Accountability for reasonableness provides a framework by which the fairness of priority setting in health care can be evaluated (Ham, 2003). One of the goals of priority setting is fairness. Many countries have articulated fairness as a goal of their resource allocation decisions, but they continue to struggle with articulating what fairness means (Cookson and Dolan, 2000). This framework was developed on these premises and has been used to evaluate, improve priority setting in various contexts and ensure that priority setting decisions are made transparently so that stakeholders, including the public, can discuss and influence the process (Daniels and Sabin, 2002).

The relevance of this framework is based on the application of its four conditions stated earlier. The framework brought out an understanding of how priorities in health are arrived at the community level, how relevant the health priorities are to community needs, the existing mechanisms of communication between the community and the structures for channeling health priorities and how the community drive its health priorities. Of interest also was the rationale that guide/inform the community in identifying their health priorities. For priorities to be adopted they should be agreed upon fairly by all the stakeholders in the community and in this regard the channels within the existing structures in harmonizing divergent views and accessibility of the priorities mainly by the consumers came out.

In summary, the assessment in this study referred to the relevance of criteria and stakeholder involvement for the decisions, the extent of publicizing decisions and their reasons, opportunities for appeal / revision and the strength of leadership/enforcement for these processes.

2.8 Assumptions

1. There is no clear-cut health priority setting mechanism at the community level in Magarini division.
2. There is limited community participation in health priority setting in Magarini division.
3. Disease burden is the key factor influencing health priority setting at the community level in Magarini division.

2.9 Definition of Terms

Priority setting: Refers to the distribution/identification of resources/tasks among competing programs.

Fairness: Refers to justice and equity in distribution of resources

Priority Setting Process: This is defined as how a team arrives at a decision. This includes defining the problem, gathering information, building alternatives, evaluating alternatives, and choosing an alternative.

Decentralization: This is the delegation/transfer of services/roles to lower levels of administration.

Inputs: These are defined as the members of the team, including the team leader. Each team member brings with him or her set of values, morals, skills, attributes, preferences, knowledge, experiences, and expectations.

Output: This is defined as the priority setting decisions made based on the decision making process.

Outcome: Health activities carried out according to decisions made and their short and long term outcomes.

Feedback: This concerns the information to communities and other stakeholders on health systems output and outcome and their involvement in systems monitoring and developments.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter is divided into four sections, namely; description of the research site, sampling design, methods of data collection and data analysis.

3.2 Research Site

This study was carried out in Magarini division in Malindi District of Kilifi County. Towards the completion of this study Magarini division had just been elevated to a district status with Marafa as its headquarters.

3.2.1 Profile of Magarini Division

Magarini division was one of the three divisions under Malindi district. The other divisions included Malindi and Marafa. Magarini division had two health centres namely, Marafa and Gongoni. There were four dispensaries spread out within the division situated in the following centres Adu, Marereni, Ngomeni and Shomela. There were other dispensaries which had been built through the support of the Constituency Development Fund at Merikebuni and Baricho. Magarini division had eight locations, namely, Adu, Bungale, Dagamra, Fundisa, Garashi, Gongoni, Magarini and Marafa.

Kilifi County is one of the six Counties forming the larger Coast province. Other counties include Mombasa, Kwale, Tana River, Lamu and Taita Taveta with a total population of 3,325,307 (KNBS, 2010). Kilifi County has five districts which include Kaloleni, Ganze, Magarini, Malindi and Bahari.

In 2009, Kilifi County had a population of 1,109,735 with male and female constituting 48% and 52% respectively. It covers an area of 12,639 kilometre square and is located in the Coast province along the Indian Ocean (KNBS, 2010). The County has four topographic features namely Coastal Plains, Foot plateau, Coastal Range and Nyika plateau. The Nyika plateau covers the largest area of the district. Magarini district has a high human settlement found in the Foot plateau and the Coastal Range areas of Gongoni, Mambrui, Marereni and Magarini. The region is sparsely populated and covered by thin vegetation, shallow depression and gentle undulating terrains.

The climate in the county is considered tropical, with 2 distinct rainy seasons, yielding 75 mm to 1200 mm of rain per year and an average relative humidity of 65%. The altitude ranges from sea level to 50m. The main economic activities in the county include tourism, fishing, manufacturing and agriculture – cashew nuts, pineapples, water melons, coconut palms and mangoes. These are associated mainly with large companies operating in the county (GoK, 2001).

The majority of the local people in the hinterland (about 68%) are considered to be in absolute poverty defined as persons unable to meet basic food and non-food requirements. HIV/AIDS is also one of the main challenges in rural participation in the district with a prevalence rate of between 15 – 17% mainly caused by promiscuity, prostitution, drug addiction and alcoholism, traditional practices such as wife inheritance, polygamy and belief in witchcraft – this trend has led to increased poverty levels in the district (PRSP, 2001-4). Magarini division received ten million shillings out of about fifty million allocated to the entire Coast region under TOWA programmes as outlined by the Kenya National AIDS Strategic Plans (KNASP I 2000-2005 and II 2005/6-2009/10) for implementation at the community level (NACC, 2009).

Hypertension, anaemia, pneumonia, tuberculosis and diabetes are the main causes of mortality amongst the population over five years in Malindi district, including Magarini in 2009. By mid-2010, accidents and HIV/AIDS were the main causes of mortality amongst the population over five years old in the district. Amongst the under five years old, pneumonia, prematurity and anaemia were the top leading causes of mortality in the district in the years 2009 and 2010. Malaria, diarrhea and diseases of the skin were also reported to be the main causes of outpatient morbidity amongst the under and over fives in the district (MDHR, 2009).

Another challenge in the district is the high number of landless people (11.3% of the households) rendering many of them squatters in private lands in the district (GoK, 2002-08). In the 2009/2010 financial year, Magarini as a constituency received 59,379,248 shillings towards assisting in establishing projects that are geared towards improving the general quality of life of the community (CDF, 2010).

3.3 Study Design

This study was a descriptive cross-sectional study that utilized qualitative methods where key informant interviews and focus group discussions (FGDs) were conducted. The FGDs were conducted to explore group consensus while key informant interviews were conducted with a view to getting individual perspectives. These were conducted in a period of about six (6) months.

3.4 Study Population

Malindi district had a population of 281,552 (KNBS, 1999). Administratively, Malindi district had three divisions, namely Magarini, Malindi and Marafa. Magarini division, where this study was conducted, was divided into three divisions, Gongoni, Magarini and Marafa. The populations in the division comprise people mainly from the Giriama, one of the Mijikenda communities. The population in Magarini comprised groups based on socio-economic (such as youth and women groups) and religious backgrounds. The study population was drawn from the three administrative divisions and residing in Magarini division and who ordinarily utilizes health services.

3.5 Sample Population

A sample population of men and women was drawn from the population in the three divisions in Magarini division. The unit of analysis for the focus group discussions was the group from the registered social groups whereas the individual member of the community who were aged 18 years and above and lived in the division was the unit of the analysis for the key informant interviews.

3.6 Sampling Procedure

To cover Magarini division which was a large area, there was need to take a sample frame of registered social groups (youth, women and herbalists) within the division. This was obtained from the District Social Development Officer.

Table 3.1 Distribution of the registered groups in Magarini division (2008)

Divisions	Groups		
	Women	Youth	Herbalists
Marafa	3	2	1
Gongoni	3	2	1
Magarini	3	3	0
Total	9	7	2

Source: Malindi District Social Development Office

Convenient sampling technique was used in selecting three (3) women groups, two (2) groups for the youth and one for herbalists. This study found that majority of the groups were either dormant, briefcase or could not be traced as there were no contacts or physical address. The same technique was also used to select twenty nine (29) respondents for key informant interviews and one hundred and sixty eight (168) participants for focus group discussions. Emphasis was made to ensure that the groups / participants selected were equally distributed into the three divisions, namely Marafa, Gongoni and Magarini based on sex and age.

3.7 Methods of Data Collection

3.7.1 Key Informant Interviews

These were conducted amongst resources persons where a total of twenty nine (29) participants were interviewed in that group. These included health personnel (one District Medical Officer, two clinical officers and four other health workers (from the Marafa and Gongoni health centers). It also included opinion leaders which comprised of three councilors, two officials of the Constituency Development Fund (CDF), two health committee members (one each from the two health centers), two representatives of local provincial administration (chiefs), two village headmen, two members of the civil society, two each for women and youth groups. Program managers were also interviewed. They included two managers of Non-

Governmental Organization and one from faith-based organization. A guide (Appendix 1) was developed and used in the interviews where the main themes included priority setting processes within the community in general and priority setting processes in relation to health issues. The interviews were conducted by the researcher with the assistance of a trained field assistant who participated in tape recording discussions and taking notes as a back-up system during the interviews. Table 3.2 shows the age and sex distribution of key informants.

Table 3.2: Age and sex distribution of key informants

Age category	Sex		Total
	Male	Female	
24 – 28	2	-	2
29 – 33	1	2	3
34 – 38	2	1	3
39 – 43	2	3	5
44 – 48	6	3	9
49+	6	1	7
Total	19	10	29

3.7.2 Focus Group Discussions

A total of twenty (20) FGDs involving between 7-11 people from the groups representing the community were conducted. The FGDs were constituted from each of the following groups that represent the community; one (1) with the District Health Management Team (DHMT), six (6) FGDs with the outpatients in the two health facilities (two (2) with males, two (2) with females and two (2) mixed), three (3) with women groups and with the youth groups (one each with men and women separate and one mixed), two (2) with the health committees (one each from the two health facilities), two (2) with participants at the chief's *baraza*, two (2) with members of projects sponsored by NGOs, two (2) with the village health committee and

one (1) each with the village headmen and at the household level. An FGD guide (Appendix 2) was developed and used and it included issues such as how priority setting in health was arrived at between the structures in the community and vice versa as regards existing mechanisms for appeal / revision, publicity, leadership/enforcement and relevance. Discussions were moderated by the researcher with the field assistant assisting in taking notes and tape recording. Table 3.3 shows the age and sex distribution of FGD participants.

Table 3.3: Age and sex distribution of FGD participants

Age category	Sex		Total
	Male	Female	
19 – 23	7	15	22
24 – 28	16	12	28
29 – 33	14	17	31
34 – 38	10	10	20
39 – 43	14	18	32
44 – 48	15	6	21
49 – 54	11	3	14
Total	87	81	168

3.7.3 Secondary Data

Use of secondary data was utilized in as far as reviewing relevant literature is concerned on various issues related to the study. In addition, internet was used to search for relevant and latest information to supplement existing ones. This was a method that was continuously used throughout the duration of the study. The other aspect included getting information on the priority setting processes in health from various sources such as Reports and Minutes of meetings within structures where the community participates. This was done by the author and was incorporated into the discussions with a view to enhancing the quality of questions used in data collection, presentation of findings and discussions.

3.8 Data Processing and Analysis

Each set of data from the key informant interviews and focus group discussions were transcribed, typed into a computer using Microsoft Word and translated into English (where applicable). This was exported to NVIVO software version 7. Under the sources, the two set of data were saved as documents. Each dataset carried all the proceedings or files saved separately. Before coding, tree nodes (and the sub nodes) which were based on the thematic areas of the study objectives were created. Coding was done after going through all the files in each of the two data sources by selecting and placing certain parts of the statements/responses in the sources under the nodes. Thematic analysis (each code) was applied and eventually described separately. Data is presented in the form of excerpts and quotes.

3.9 Ethical Issues

The study was presented to the Kenya Medical Research Institute and National Ethical Review Committee for scientific and ethical approvals, respectively, under the REACT project. A written consent form (Appendix 3) was used to obtain informed consent prior to commencement of data collection from informants and / or participants who agreed to participate in the study. Permission for use of tape recorder during data collection was sought from informants and participants before the interviews/discussions. Informants and participants were assured that their contributions in form of responses together with their names shall be kept in confidential and that no names were to be used in any report.

HEALTH PRIORITY SETTING PROCESSES AT THE COMMUNITY LEVEL

4.1 Introduction

This chapter presents and describes health priority setting processes, how priorities are made / arrived at, whether priorities reflect the wishes of the community and existing mechanisms to challenge/revise the set priorities at the community level, if any. In trying to ascertain and describe health priority setting processes and subsequently community participation in the same, this chapter looks at the processes involved in health priority settings in structures in the community.

This study found three stages of processes where health priority setting is done in the following levels; at the health centers, social institutions and the Non-Governmental Organizations operating in Magarini but differ on the details in the three levels which the study assessed. In all the levels, the community appears to be in the last (third) stage either being invited through community or village elders or allowing the community to deliberate and agree, through consensus, on the best priority concerns often based on the already itemized health priority areas of the institutions in the community. The first stage in all the levels shows that health priorities are identified and agreed upon either by the top organs like DHMB/T for the health facilities or program managers or international agendas for the NGOs.

4.2 Health Priority Setting Processes at the Health Facility Level

In this level, this study found that there are three stages where health priority setting is done. Stage one is where DHMB/T in its meetings identify, discuss and agree on health priorities for all the health facilities in the district. This finding is similar to what Bukachi, *et al.*, (2013) found in their study that priority setting in the entire Malindi district involves two major management teams (DHMB and the DHMT). In the second stage, the in-charges of the health centers organize meetings based on the agenda and the health priorities of the DHMB/T as noted by a respondent:

It is within the health policy that discussions with colleagues in staff meetings are initiated as a priority before discussions at the community level which is done monthly (KI, male, 37 years).

Priorities and decisions are not based on prevalence of anything other than the views of the Chair. But decisions on priorities regarding technical issues such as availability of drugs, modifications / construction / upgrading of facilities, procurement were noted to be decided upon by the DHMB/T as recommended in the MOH guidelines (MoH, 2009). This was where the community was assumed not to understand specific details pertaining to the technical elements in as far as health is concerned and therefore unable to offer any meaningful option or even having the capacity to deliberate on the priorities.

The community which is involved at this level through its representatives in the board has not raised any concern demanding to know the real justification(s) for reserving or withholding logistical, technical and administrative priorities to the central government. One of the functions of the DHMB, established in May 1992, was to represent community interest in all issues relating to health planning process of the district and even participate in identifying implementation problems and corrective actions that represent the feelings and wishes of the community.

Stage three is where monthly discussions with the community under the outreach programs. These are supported by feedbacks from monthly meetings with the community representatives, as observed by one respondent:

We tell them what has been discussed and endorsed. For transparency, the finance treasurer comes from the community (KI, male, 37 years).

In some health centres, this study found that the community is increasingly becoming aware of the services offered. This could be informed by, among other factors, the advocacy efforts of both the government and private agencies through the various partnerships between them on the one hand, and with the community on the other hand. This has seen communities like the ones in Magarini demanding for all the health services especially in the public facilities. To some extent, through continuous sensitization or education, the community can even improve the ability of individuals to produce health themselves through better lifestyles rather than relying on health services. There is also evidence that better basic education can, through general improvements in literacy and specific health studies, increase desired and actual use of health services. Studies in Tanzania (Leonard, *et al.*, 2002) suggest that, far from being passive consumers, patients in the community actively seek out not only the best-known provider but the best facility for a particular illness. This study found, for instance, that the community demanded for 24-hour service provision and adequate supply of drugs in one of the health facilities within the study area. This was an opportunity when the community was felt to be in need of services, as noted by one respondent:

These people that go out for outreaches got the idea from the community that they need services all the time including during the nights (KI, male, 39 years).

This study found out that the decision to offer services up-to and including during the night was floated by a representative of the community. It first got some resistance from some members of the health committee especially the health providers who did not want to work

mainly in the night. But after lengthy deliberations citing the pros and cons of the new development, it was agreed, through voting, that all services be offered within the 24 hours in all public health facilities. This study noted that the main reason advanced by the health personnel especially those living in urban areas was the issue of working during the weekends which did not go well with many of them arguing that they needed time to be with their families. This study however noted that many health providers were providing services either in their private clinics or were employed in private health facilities during the night and over the weekends. This study noted that providing services even at nights had greatly improved the level of trust between the health management team and the community as services have been availed. One respondent observed:

People never used to like this facility...but after getting out sensitizing the community through *barazas* that the services will be provided at all times including the nights and weekends, patients came within no time...We therefore had to make some allocation for essential drugs. With that most of the problems facing them have been solved in our facilities and many of them are now happy (KI, male, 45years).

4.3 Health Priority Setting Processes at the Village Health Committee Level

As proposed in the MOH guidelines, the village health committee are supposed to be the overall overseer of services provided at the community level, in the village and therefore to serve as the link between the village and the household. Through the committee, the Chair will mobilize community resources and undertake social mobilization for implementation, reporting to the Dispensary Committee in matters of services at the level one and supported with the technical support of the CHW (MOH, 2007).

In addition, the village health committee is envisaged to work in partnership with different sectors working in the community in planning for department and sectors to work together with a common vision at community level; lobbying and advocacy to gain political support

and commitment based on a common stronger voice for change and strengthening the economic capacity of households through professionally managed initiatives to expand options, among other tasks.

For the above to be realized, this study noted that the functions of the village health committees seems to be very enormous and overwhelming to existing ordinary committees which does not have the basic knowledge, expertise and better understanding of health management in the village level. Specifically, issues to do with planning, implementing and evaluating activities at the village level are tall orders for committees which are appointed or elected based on their socio-political backgrounds which, in most situations, have no relevance to health management.

Further, through the community health workers who work as volunteers, this study found out that some village health committees had attempted to sensitize the community against diseases which were disturbing people in the area. This study noted that some of the committee members were not aware of their mandates. Some members of the committees pointed out that they had not been recognized either by the community and the local provincial administration, as noted by one participant:

To say the truth, we have not been recognized... we have not gone there to identify ourselves as a village health committee. Therefore we have not been recognized as such...Even the committee itself lacks the commitment to hold a meeting with a view to strategizing on the best ways of sensitizing the community. We are just here at the community (FGD, male, 46 years).

As a result, this study observed that there were no linkages between many village health committees and the facility committees. In that regard, many members of the village health committee in the focus group discussions noted that they had not seen any activity or initiative undertaken by the health facility committee at the village level.

4.4 Health Priority Setting Processes in Social Institutions

Social institutions such as women and youth groups are structures which are largely formed by individuals who get together based on common interests. Other than participating in self-help activities that are geared towards improving their social welfare, this study found out that the social groups (such as women and youth) also participate in sensitizing the community on health issues such as HIV/AIDs through drama and health talks. At this level, there are three stages where health priorities are identified. In stage one are meetings that the leadership lead in identifying health related ideas to be discussed leaving members with no options other than to either discuss and approve or simply endorse the same. It is in second stage that the modalities of carrying out an agreed action(s) are also discussed amongst members and approved through consensus.

In carrying out their activities, this study also found that the youth in their groups choose, through consensus, to collaborate with the health staff from local facilities and NGOs such as World Vision and the Kenya Red Cross in visiting other youth in schools upon invitation by head teachers to sensitize them on issues that are also agreed upon in their meetings. One respondent observed:

We agree on where we want to visit and how we will present our message(s). Take an example of diarrheal diseases due to stagnant water in this area. We agree to visit areas like schools or market places to sensitize people about the need to take precautions like boiling drinking water. We agree on how we will present that message like through drama or just talking (KI, male, 40 years).

Both women and the youth, in collaboration with the local provincial administration, also have activities, agreed in their meetings through consensus, to sensitize the general community within villages on vices such as alcohol and drug abuse, among other issues. Many youth and women bear the burden of poor health owing to the effects of economic hardships, war, unemployment and poverty or poorly distributed wealth. Diseases such as HIV/AIDS, tuberculosis and malaria, among others, are subjecting women and youth into more misery. Poor hygiene, persistent behavioural risks, poor basic sanitation and new and emerging diseases are contributing to a deadly mix that is changing the classic picture of healthy youth and women.

In the youth and women meetings, this study found out that the agenda is drawn by the chairpersons. In such situations members were noted to be having no objections in the way their leaders were proposing and presenting issues during the meetings. It is in the third stage that the community is later given the opportunity to just raise their feelings or views on what is being presented to them in any forum decided upon, through consensus, by the groups. One respondent noted:

We have not encountered a situation where the community has rebuked us on what we are conveying across. We mingle with the audiences and they get to air or pass their comments to us. Mostly teachers have forwarded their comments shortly after we have performed in their schools (KI, 37 years, female).

At the village level, the Chief convenes leaders meetings to deliberate on various issues (including health) which in many instances from guidelines or directives from higher levels. In such meetings, the Chief consult the leaders on how best to undertake the guidelines or directives. This study found that the rationale for the consultations is to reach out for favourable and popular decisions to the majority of the community members, as observed by one respondent:

4.5 Health P... General consultations are made on issues before decisions are made,...we discuss and look for answers, what do we do?...and if decisions have to be made then we look for the most beneficial...and you comply with the choice of the majority. Even in church, the decisions have to be deliberated upon and an agreement reached (KI, male, 56 years).

In any sitting, the Chief listens to all opinions and proposes decisions but if he/she cannot then he/she will have to seek the opinion and views of the members to reach the best decisions from all the suggestions/options. Decisions are not taken based on who initiates the issue but generally those that are thought to be beneficial to the whole community carry the day, no matter who gives them. Specifically, this study found out that there are no individuals whose opinions are valued most in some structures due to his / her age, wealth or knowledge, as noted by one respondent:

It does not matter who gives suggestions. We don't bother who you are...we bother about the weight of the issues (KI, female, 29 years).

Health priority setting and the processes involved are difficult tasks and complex issues especially at the community level in as far as balancing between the health needs and demands of all the groups, on the one hand, from other competing issues like poverty and illiteracy, on the other hand. The processes are tedious ranging from determining the health needs and their rationale to setting explicit criteria and formal process for priority setting and who should or not participate in priority setting. Setting priorities involves making decisions about identifying and recognizing important health needs of the majority groups and how the priorities will be addressed. The selection of priorities can be driven by factors ranging from who advocates most vigorously, or which stakeholders have more influence and resources to invest. But the most challenging issue in health priority setting is getting a group to decide on health issues affecting and on behalf of the community from other competing needs and the method of getting to the priorities set.

4.5 Health Priority Setting processes in the Non-Governmental Organizations

With a view to improving health care delivery and the overall performance in health sector performance, the government of Kenya introduced series of reforms which have been discussed in Chapter Two. As a strategy towards addressing the challenge of providing access, efficiency and quality of services to the ever growing population, the Government of Kenya introduced the Kenya Health Policy Framework Paper and NHSSP II as an intentional effort whose aim was to create room and encourage the provision of essential and discretionary health services by involving the participation of the private sector and NGOs in underserved areas.

Through the Decentralization Action Plan (DAP) that was jointly developed between NGOs and the Ministry of Health, the District Health Stakeholder Forum (DHSF) was established to bring together all health actors in the districts to address health concerns and to act as a forum for participatory planning (Wamai, 2008). There are several stakeholders in the health sector in Magarini division and the larger Kilifi County, which have mounted various intervention programs based on their priorities. World Vision, the Kenya Red Cross, Christiano Internazionale Sviluppo Dei Popoli (CISP), DANIDA, USAID and the Ministries of Agriculture, Public Health and Sanitation and Medical Services are the major stakeholders in the health sector that implement activities singly or in partnership in the County.

Specifically, the NHSSP recommended that the government engage stakeholders especially the private/NGO health providers for them to take up more discretionary health packages which are mainly curative (ROK, 1999). This saw the private sector and the NGOs joining hands with the Government of Kenya in series of developments that were geared towards developing national health sector strategies. This fact was supported by the findings of this

study that through an elaborate partnership many of the stakeholders operating in Magarini have and still continue to collaborate in many aspects especially in the health sector.

This study found from the key informants that the Kenya Red Cross, for example, joined efforts with other stakeholders such as the World Vision, World Food Program (WFP) and the Ministry of Health and Sanitation in providing priority services such as supplementary feeding and general hygiene and sanitation, jigger advocacy and in screening people for bilharzias especially amongst children, pregnant and lactating women. The priorities were noted to be mainly from the donor point of view. One participant noted:

Water-borne diseases have not been given priority it deserve by the relevant stakeholders but from our screenings from a small population we have realized that about 65% of people screened for bilharzias was positive. It is from this that we advise the community on the need to visit health facilities for check-ups and screening (KI, male, 52 years).

More often, the stakeholders especially the international NGOs, as this study found, take lead in identifying broad priority concerns either based on their national or international agendas, own assessment or recommendations of reports from the government ministries and or departments such as Public Health and Sanitation, Medical Services, Agriculture and KEMRI, among others. For instance, The Kenya Red Cross and USAID through Aphia Plus project, on the one hand, has a common priority of distributing water purifiers especially after reports of outbreaks of diarrhoeal diseases from the Ministry of Health and Sanitation are noted and offering training to traditional birth attendants and linking them to health facilities. Also, the need to train TBAs on the importance of encouraging and accompanying pregnant women to health facilities to deliver, for instance, arose from NGOs' assessment that pregnant women were giving birth at their homes under poor circumstances. The activities were reported to have been agreed upon by the stakeholders based on their priority areas which may not

necessarily emanated from the concerns of the community. The community had not seen any issue in pregnant women giving birth at their homes, a practice that has been going on since time immemorial.

This study also found that priority setting in some NGOs begin by getting information from the communities they serve from the beginning of their respective programs through public *barazas* organized at the community level in conjunction with the local provincial administration up-to the implementation of specific activities from those programs. One informant observed:

We sell the idea to the local provincial administration so that they understand and if they agree we tell them that we need to talk to the gatekeepers like the assistant chiefs, village elders, women and youth groups, area councilors and other influential people. We bring them to a meeting because the concept needs everyone' involvement. Every village elder is given the opportunity to call a *baraza* in the presence of the chief or assistant chief. They will discuss with the people. Our task is to clarify the process where necessary and if they accept the concept they call us to say they are ready to embrace it(KI, male, 46 years).

This is followed by assessing the benefits and overall determination of cost-effectiveness of health interventions based on the priorities identified up-to resource allocation done by the managers of the NGOs. For other NGOs, invitation and involvement of the community into their priority areas ranges from sensitization, prevention, management, treatment and control of diseases such as malaria and typhoid. This study found that invitation to participate in priority settings was geared towards the realization of the set strategies of the stakeholders and not necessarily as priorities of the community such as inviting the community to participate just in choosing its members as volunteers or committees to join those activities. There were also situations when the community was given the opportunity by certain NGOs to identify its priorities from an existing list of already determined priority concerns of the NGOs, as noted by a respondent:

After getting a long list of ideas, we ask them to prioritize and ask them to rank them starting with the most pressing priority and on how best to assist them (KI, female, 44 years).

Towards establishing a mutual partnership with the community, the local provincial administration was found to be playing an important role in providing the needed linkage between the community and the stakeholders. The local provincial administration was noted to be ensuring that health priorities identified and agreed upon by all the stakeholders, including the community, are implemented. Moreover, it also create forums through which dialogue that are geared towards exchange of ideas/concepts between the stakeholders including the community are organized and calls for meetings and even take part in some of the development and or implementation of identified priorities such as sensitizing the community on HIV/AIDS, nutrition, immunization and malaria, among other activities.

In conclusion, the findings in this chapter has shown that health priority setting processes at the community level are tedious and vigorous ranging from striking a balance between determining the health needs of the stakeholders and their rationale and demands of the majority of all the groups in the community. The study found out that there are three stages of processes where health priority setting is done but differ on the details. In the three levels, the community appears to be in the last (third) stage through invitation.

CHAPTER FIVE

COMMUNITY PARTICIPATION IN HEALTH PRIORITY SETTING

5.1 Introduction

This chapter presents and describes community participation and or involvement in health priority setting. In describing community participation, this chapter looks at some of the social structures where the community through its representatives is involved and subsequently participates in health priority setting at the community level.

5.2 Community Participation in Health Priority Setting

The idea of making the community participate in the general operations of health activities was formulated and recommended by the WHO in 1983 under the district health system and many countries including Kenya have adopted the approach in support of Primary Health Care. The underlying aim of the approach was to take health services closer to the people at the community level and provide them with opportunities to have their own health concerns factored in the health priority settings and decisions at that level. While supporting the approach, a key informant observed:

This community has been ignored for a long time in making health priorities and other decisions on issues affecting their present and future lives (KI, female, 45 years).

The district health system whose definition has formed the basis for delivery of health services includes all institutions and individuals providing health care in the district, whether governmental, social security, Non-Governmental, private or traditional. In that definition, a district health system consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces and communities, through health and other related sectors. Primary Health Care models consider users of health-care services as beneficiaries

who are just there to be given health care, rather than active participants with choices to make about the health outcomes to which they aspire. Instead of creating opportunities and avenues for the consumers (the community) to fully participate right from the inception of their products, the district health systems seem to have ignored this essential contribution. However, the implementation of the approach has been influenced by national health care priorities as found out by this study from a key informant who stated:

We are extra careful when it comes to making priorities at the facility level as national guidelines, at times in form of directives, supersede local priorities. In those scenarios our hands are tied, you have no choice but to obey the order otherwise some form of penalty may be meted against you if you disobey (KI, male, 46 years).

This study found that community participation, which encompasses groups of people sharing common needs, goals and interest, is an important approach for realizing meaningful development at the grass-root level. This finding concurs with findings from other studies that add that community participation is one of the factors in the community capacity building process that allows involvement of people in the various stages of decision making (Aref and Ma'rof, 2008; Bozlul, 1994). It is one of the ways of empowering people at the community level to take part in community development and especially in decisions affecting their lives. Another study by Daniels and Sabin, (2002) also emphasize that it is through community participation that real-life expectations based on their experiences are nurtured. In this study, one informant observed:

Making the community come together enables them to have a better bargaining power in various matters, including health *kwani umoja ni nguvu utengano ni udhaifu* (together we stand divided we fall) (KI, female, 38 years).

Data from key informants shows that the importance of having the community participation in decision making and priority setting levels is to promote some sense of ownership and control among the people and eventually create an opportunity for the community to achieve the capacity to resolve community matters. Though this is a finding shared in a study by Lasker, *et al.*, (2001), a study by Cernea (1992) warns that participation in itself does not adequately solve the issue of ownership of local initiatives. Ashley and Roe (1996) have described community participation as a spectrum from passive to active involvement to full local participation where there is active participation and venture ownership. In this study a respondent stated:

The overall essence of involving the community is to improve health care provision in two-fold; first, to facilitate the views and feelings of the community; and secondly, to relay feedback on health concerns from the ministry through the facility to the community and vice versa. People will see a window of being the *wenyeji* (owners) of priorities and decisions and therefore an opportunity to advance their perspectives (KI, male, 47 years).

In community engagement, mutual learning, adapting and responding to new knowledge are some of the characteristics involved in community engagement. The goal is to be able to meet and understand the needs of the community and advance feasible solutions to solving problems for the community (Gibbons, 2008).

5.3 Community Participation in the Health Facility Committees

In order to resolve constraints in the health sector in Kenya, several reforms have been initiated in the sector. The reforms have been discussed in Chapter Two. The outcome of the reforms was, among other issues, the establishment of the District Health Management Boards and the District Health Management Teams. The essence of that effort was to allow greater participation of the community in the management of health service delivery and to strengthen the implementation of activities at those levels (MOH, 2006). The setups, as found

by this study, were to provide management and supervisory support to rural health facilities which include sub-district hospitals, health centers and dispensaries.

To be able to ensure effective and successful delivery of services, the Ministry of Health through KEPH program has put up proposals to establish structures and defined their functions in a bid to support service at level one facilities. At level one, the governing structures is expected to be based on location, sub-location and village. These are supposed to be linked to local health facilities within them so that each structure is responsible for a geographically discrete unit based on an administrative division. The implementation of services at the level one facilities, which is yet to be completely operationalized, requires the formation of linkage committees at these levels that would have the specific responsibilities based on the respective levels.

KEPH through its National Health Sector Strategic Plan 2005 recognizes communities as the foundation of affordable, equitable and effective healthcare. On this regard it has advanced some approaches towards the realization of the community as a strategy whose goal is to enhance community access to healthcare with a view to reducing poverty, hunger and child and maternal deaths. This approach could have been informed by worsening trends in the health status of the people as reported in various reports such as the Kenya Demographic and Health Surveys. For instance, infant mortality rates in 1998, 2000 and 2003 were 72, 74 and 77 per 1000 live births, respectively (MOH, 2006).

This study found that the health sector reforms and the primary health care embraced community-based healthcare (CBHC) strategy of decentralization to formalize people's participation and contribution in determining their own health priorities as well as in resource

mobilization, allocation and control. It was envisaged that reversing the mortality trends through the CBHC approach will be realized. The approach was planned as the mechanism through which households and communities take an active role in health-related development issues. Specifically, the approach proposed that the households and the communities were to be actively and effectively involved and enabled to increase their control over their environment in order to improve their own health status. To be able to achieve this, this study noted that the strategy which envisaged building capacities of communities to assess, analyze, plan, implement and manage health and health related development issues had not been implemented. Under the same approach, the community was to be empowered to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services. However, this study found that the strategy was silent on the specific measures, methodologies and the guidelines of implementing its proposals and specifically on how to involve the community.

In this regard, the intention of the decentralization policy was to enable the community to participate effectively in decision making processes related to matters of health at the community level, as well as at the interface between level one and levels two and three. The lower levels of care (levels two and three) were more or less consistent with the administrative and development nodes, although sometimes their catchment population may not correspond to administrative boundaries, within the community and can therefore be robust and sustainable. Health committees at divisional, locational, sub-locational and village levels were expected to provide communities with sufficient representation and voice in all issues affecting service provision at level one.

Health facility management committees, made up of community representatives and the facility in-charges are required by the guidelines to meet at least monthly to review progress from the indicators and baseline information generated through the community-based information system and facility-based information system and to make decisions for continued actions for health, at facility, community, household, political and administrative levels (MoH, 2006). But this study found that such meetings are only held in most facilities whenever the in-charges of the facilities together with the Chair persons of the management committees feel that they have a message mainly from the Ministry of Health headquarters in Nairobi or whenever there is an outbreak of an epidemic.

According to the MOH guidelines, the coordinator of the CHWs at the facility level is supposed to collate the data obtained from the CHWs and the health facility in-charge together with own information and share the information with the other sectors by displaying it on notice-boards, among others. In addition, the organization and management of services in facilities at level one are to be integrated into the health sector and local government reform frameworks. This study found that the information posted on the notice-boards were those generated by the facility in-charges from patients who visited the facilities and not from data collected by the CHWs from the community. Further, the DHMB and DHMT were to provide governance and technical support, respectively, to level one activities which were to include planning, implementation, monitoring and supervision. This study found that the guidelines have not been fully implemented.

At the divisional level (and level three health facilities), the guidelines informed that a sub-committee, responsible for health services in the whole division, was to be established but also functioning as the health centre committee where there was a corresponding health

centre. Specifically, the health centre committee was supposed to, among other roles, oversee the functioning of the health centre in support of level one service provision and mobilize resources for development of the health facility as well as supporting outreach and referral activities. Those roles as expressed by the guidelines were found by this study to be too technical to be realized by a health centre committee as membership of the committee was found to be made up of a conglomeration of individuals selected or picked from diverse social, cultural, religious and political backgrounds merely to sit in the committees. But in that arrangement, as stipulated in the guidelines, each village was given the opportunity to elect individuals based on their own criteria to the committee in public meetings held by village elders and supervised by the Chiefs. This study found that guidelines were not clear on the criteria used in choosing membership to the various health committees. A key informant stated:

The administration normally organizes that in cahoot with some friendly individuals and just selects from them (KI, male, 47 years).

This study found from focus group discussions that of the many participants who were aware of the existence of the health committees, most of them were not aware of the mandates or composition of the committees. A few of them noted that certain individuals obtained appointment letters straight from some Chairmen of the health committees without consulting or involving the entire committee or the community. One participant noted:

We only hear that so and so has been appointed by the Chairman. Someone even showed me a letter to that effect. The Chairman just appoints people whom he likes to work with based on his selfish interests (FGD, women, 43 years).

Whereas most key informants pointed out that the community was fully involved in the selection of the health committees and in identifying their priorities, many participants in the discussions groups explained that they were not involved in the process emphasizing that the

information on the need to have elections had not been communicated to them in good time. That practice contradicts the issue of relevance, one of the four conditions identified by “Accountability for Reasonableness” approach which emphasize that priorities should be made on the basis of reason, that the priorities should be relevant to the needs and wishes of the community, that decisions and their rationales be transparent and made publicly accessible and that there should be opportunities to revisit and revise decisions in light of further evidence or arguments and there should be a mechanism for challenge and dispute resolution (Gibson, *et al.*, 2005).

Regarding the functions of the health committees, this study found from most key informants that some of the health committees often go out to collect and collate views, needs and or wishes of the community on the services offered at their facilities or their general health concerns. One respondent observed:

We occasionally get to the community to enquire about what their health concerns are especially in regard to the services provided in our health center (KI, male, 45 years)

Although the MOH guidelines that set-up the committees does not detail the methodologies of performing their tasks, the decision by the committees to get to the community in an effort to get their views on any activity was noted to be the duty of the chair person. This study noted that chair persons never consulted their members regarding specific action points but react to issues based on their own judgment.

One aspect that seemed to have divided some committees was resource allocation to specific project(s). An example was the issue of what one committee called ‘serious shortage of staff quarters’ especially for the technical staff. Although this study, on the one hand, found that

staff houses did not exist in many health centers, many committee members noted that allocating resources to construction of staff quarters was not a priority to them and to the community at large but a priority of the committee chair persons.

Worse still, the community had not been consulted on the need to have housing units constructed. Specifically, key informants in Gongoni division explained that the construction of maternity wards which was a priority of the health committee was not a concern of the community though they were involved at the negotiation level at the district level when money for various projects in the district were being allocated to projects. That was where some people from the community had been invited by the health committee to travel to Marafa division to bolster their negotiations for allocations for their projects. One respondent maintained:

The new staff houses will house staff to serve the community at all the times. When you are sick in the night, as the Giriama say, the problem somehow increases than in the day as you rest in the night. The *mdudu* (virus) is activated when you are resting (KI, male, 49 years).

Participants in the FGDs noted that the health committee did not consult or involve the community in health priority settings in their meetings mainly because majority of the committee members were found to be appointed or proposed by opinion leaders and not elected. The study noted that the opinion leaders passed their priority concerns and other agendas through members who had been appointed to the committees, no wonder many of the priorities of the committee did not therefore reflect the needs and wishes of the community. This made most participants to complain that they were not satisfied with the priorities, seen through services, offered by the committee in some health facilities. One participant observed:

We have not seen the committee moving around getting views of the community. My neighbor is even a committee member but he has not even informed me of any service or tried to get my views on certain services or issues touching the facility. We need to be called upon to participate fully because we have the capacity and knowledge to engage on issues that affect us (FGD, female, 48 years).

Opinion leaders can successfully promote the adoption of evidence-based practices. The selection of opinion leaders to promote evidence-based care does not imply the use of sophisticated technology or processes, and it should be possible to implement the intervention even in the most under-resourced settings. According to Rogers (1995) opinion leadership is the degree to which an individual is able to influence other individuals' attitudes or overt behaviour informally, in a desired way with relative frequency. This informal leadership is not a function of the individual's formal position or status in the system; it is earned and maintained by the individual's technical competence, social accessibility, and conformity to the system's norms. When compared to their peers, opinion leaders tend to be more exposed to all forms of external communication, have somewhat higher social status, and to be more innovative. However, the most striking feature of opinion leaders is their unique and influential position in their system's communication structure; they are at the centre of interpersonal communication networks – interconnected individuals who are linked by patterned flows of information.

As to the steps taken by the community with a view to raising or addressing their concerns, this study found from many participants that though the community had acted on some aspects in service delivery (like demanding the removal of a doctor), they were still unaware of where and how to report issues to do with the attitude and practices of the health staff. The few who reported to know how to pass their grievances mentioned that they did not have the

space or where to do so arguing that the relationships amongst staff in some health facilities was personal and therefore complaints are dismissed. One participant noted:

There was a woman who brought in a complaint on the delay in getting services and when I informed the Chairman he told me that he was going to raise that matter with the committee. Instead, he went back and rebuked patients and shouted at her! We find him impossible to listen to complaints (FGD, female, 45 years).

It is evident that majority of the people in the community may be aware of the existence of health committees but not their mandates. Indeed, even the majority of the committee officials were not aware of their own expectations as stipulated in the MOH guideline and that the basis of what they were pursuing was not informed by the wishes and or feelings of the community but their own individual or group plans. This could be attributed to a failure by the MOH guidelines and the community criteria to set the minimum level of education as a prerequisite to getting elected to the committee in order to prepare them, at least, to interpret the management guidelines.

5.4 Community Participation at the Village Health Committees

As proposed in the MOH guidelines (2007), the village health committee is supposed to be the overall overseer of services provided in Level one, in the village, and therefore to serve as a link between the village and the household. Through the committee, the Chair is to mobilize community resources and undertake social mobilization for implementation and report to the Dispensary Committee in matters of services at the level one, among other tasks. In addition, the village health committee was envisaged to work in partnership with different sectors working in the community in planning for department and sectors to work together with a common vision at community level and strengthen the economic capacity of households

through professionally managed initiatives to expand options, among other tasks. This study found that the guidelines on this aspect had not been implemented as proposed.

For the guidelines to be realized, this study found that the functions and expectations of the committees at the village level seemed to be very enormous and overwhelming to existing ordinary committees which do not have basic knowledge, expertise and better understanding of health management at the village level. Specifically, issues to do with planning, implementing and evaluating activities at the village level are tall orders for committees which are appointed or elected based on their socio-political backgrounds which, in most situations, have no relevance to health management. Some of the committees were found to be unaware of their mandates while others had not even gotten any communication from the appointing authority that they exist as committee members. Moreover, some of the committees claimed that they had not been recognized either by the community and the local provincial administration, as remarked by one respondent:

To say the truth, we have not been recognized... we have not gone there to identify ourselves as a village health committee. Therefore we have not been recognized as such... Even the committee itself lacks the commitment to hold a meeting with a view to strategizing on the best ways of sensitizing the community (FGD, male, 46 years).

Linkages between committees both at the village and facility levels help in identifying common approaches of addressing health concerns of the community in order to minimize sufferings.

5.5 Community Participation in the Non-Governmental Organizations

According to Chifamba (2013), community participation in rural development is a basic operational principle of rural development because the community, as the beneficiaries of the projects, has been seen as consumers of services. There are several organizations implementing various programs in Magarini division as health development partners in provision of socio-economic and health services. This study found out that organizations such as the Kenya Red Cross, World Vision, CISP and USAID, among others, have been in the division for varying periods but their priority areas are directly or indirectly geared towards complementing priorities of the line ministries of Public Health and Sanitation and Medical Services. The priorities range from implementation of interventions such as provision of basic health services, advocacy on various health issues such as HIV/AIDS, tuberculosis, malaria, water and sanitation and training of TBAs and or volunteers/community health workers to operate community health units.

In delivering their services to the community, this study found that the level of involving the community and how it is involved in their priority areas vary from one organization to the other. Overall, this study found that majority of the organizations offer an opportunity to the community to participate in making their priorities as noted by one participant:

We give the community an opportunity to participate in choosing volunteers to visit homes and schools giving medicine and ensuring that medicines are taken on time and at times feed babies or at least ensure that they are fed (KI, female, 46 years).

The Kenya Red Cross has been in the district since 2005. Its priority areas have been on various programs such as agriculture (through provision of inputs and materials), home management of malaria, nutritional support, jigger campaigns and food-for-asset. This study found from the informants that working through about 180 volunteers selected by the

community to work in each village and trained on various skills, the organization involve the community in many of its activities ranging from sensitization, prevention, management, treatment and control of diseases such as malaria and typhoid. The Kenya Red Cross partner with other stakeholders such as World Vision, World Food Program (WFP) and the Ministry of Health and Sanitation in providing services such as supplementary feeding and general hygiene and sanitation, jigger advocacy and in screening people for bilharzias especially children, pregnant and lactating women.

When the Kenya Red Cross was carrying out what it referred to as re-targeting of programs and or activities, the community was invited (including the local provincial administration) to attend to their planning meetings as a way of making the community own the activities and not necessarily to give them an opportunity to add the priority concerns of the community. That practice was noted to be the same after the organization had identified its health priorities. In situations where the organization intended to support the vulnerable members, as their priority, public meetings were held just to give the community an opportunity to participate in identifying people who, according to their interpretations and understanding, were considered most vulnerable. One respondent observed:

A Secretary is chosen from amongst them to write down names of the most vulnerable people. We take the list and read it out aloud again to everyone. Towards the end, they may amend the list that they have forgotten so and so or so and so has been left out and yet his/her status is even worse (KI, female, 48 years).

Most NGOs have realized the role played by the traditional healers and traditional birth attendants in the study community. And to offer better services, many TBAs have been trained with a view to assisting in advancing and scaling-up health services and programs such as taking pregnant women to deliver at the health facilities, among others. This study

also found that the APHIA Plus is holding monthly meetings with the Community Health Workers and the TBAs under the Community Health Units at every health facility with a view to getting feedback from the community and vice versa on various issues touching on their project. But, even with the training offered there is a challenge, as observed by a respondent:

Some TBAs still go back and do the same old ways of doing things. Women will argue out that they have been doing that – giving birth at home - for all other children for a long time. They ask questions like ‘Why go to the facility where we are made to suffer by paying a lot of money, where customer services are wanting?’ (KI, female, 46 years).

The role played by TBAs has been demonstrated in other findings such as a study in Nigeria that show that respondents believe that traditional healers and the TBAs can play meaningful roles especially amongst the rural dwellers in family planning, screening of high-risk pregnant mothers, fertility/infertility treatment and maternal and child care services (Imogie, *et al.*, 2002). The main reasons for the preference included their availability, accessibility and cheap services which has enhanced the faith of the population in the efficacy of their services.

Open forums held at the community level with relevant stakeholders such as TBAs and CHWs and the project managers were aimed at, if handled fairly, defining common grounds and feasible approaches of realizing full benefits of the intended programs especially those targeting women and children. This was a deliberate milestone which was geared towards capturing and incorporating feelings and wishes of the community into the various components of the project. One respondent stated:

We hold monthly meetings with CHWs and especially the TBAs who have really assisted us to access the community with ease. We are interested in addressing health issues at the community level to ease congestions of sick people mainly women and children we see in our health facilities (KI, male, 48 years).

Based on the mortality and morbidity rates, the health concerns of women and children have not been adequately addressed in many rural communities especially in regions with high illiteracy levels such as in the Kenyan Coast. Although there are concerted efforts to address those issues through the MOH facilities as envisaged in various policy documents, the pace at which the services are availed at the community level continue to be one of the challenges influencing priority setting at the community level.

Aphia Plus project funded by USAID was another NGO operating in the Coast region. This study noted that the project has been involving the community in many of its activities ranging from sensitization, prevention, management, treatment and control of diseases such as malaria and typhoid. In their arrangements, the community was being invited to attend to meetings which were reported to be organized within the community. It was noted that the project managers were the ones that determined the objectives and the agenda of meetings derived from the overall goals of the project and not necessarily from the needs of the community. But many a times, this study found that the project managers were making assessments on the needs of the community through informal consultations and sensitization forums which did not include representatives of the community. To be able to offer services to the community and as a way of ensuring that the project was seen as driven by the community, the project managers noted that there was need to have volunteers from the community. In that regard, the community was invited to meetings where they could participate in choosing volunteers to visit homes and schools giving medicine and ensuring that medicines are taken on time, among other expectations.

At the NGO level, community participation in priority settings and decision making was partial. The community is only involved in choosing priorities from a prepared menu of health priorities already identified and given prominence by the overall set-out goals. The implementation was done by the communities in consultation with NGOs which were noted to be providing technical input through its staff at the district levels such as financial expert to help in establishing plans. This study found that the community was not involved at the technical evaluation of the project activities.

The participatory approach in community development has been described as more effective

The bottom-line of any participatory approach like the one adopted by the institutions mentioned above was to provide the community, who were the consumers and general beneficiaries of the outcomes of meetings, with an opportunity to identify, contribute and share priorities and advance methodologies that does not injure the feelings and wishes of the majority of all the categories of people at the community level. When the members of the community are involved and given the opportunity to participate in priority setting and general the decision making processes, they develop a sense of acceptance and ownership towards the project (Rogers, *et al.*, 2008) and therefore drive the main aspects in project implementation and general management. After all, the essence of participation is to involve all the relevant stakeholders in the community, especially the voiceless (such as children, women, disabled, old and elderly, farmers), in increasing the capacity of the people to chart the course of their destinies in collaboration with others. They need to be involved in all the processes and participate in formulating the outputs and outcomes of the intended initiative with a view to ensuring that the desired results are realized. This allows the community to exert greater influence and have more control over the decisions and institutions that affect their lives.

Communities are sensitive and cautious to any form of change depending on the issues, agents/proponents of change and the tactics used to propagate the change(s). This behaviour may be construed to mean that the community is slow and probably not receptive to change. Moreover, such an approach, if not handled with caution, may be interpreted as a way of exerting itself into the community by creating an opportunity for people friendly and loyal to its system.

The participatory approach in community development has been described as more effective when it utilizes the principles of self-help, felt needs and participation and are therefore valuable in mobilizing communities to achieve their goals (Bhattacharyya, 1995). While doing that, the approaches can unintentionally give more power to already empowered groups in the community. In any society, there are groups which have less power because of under representation and exclusion due to socio-economic, cultural and political backgrounds. In this regard, participatory approaches may give more power to powerful groups if unchecked. Increasing the participation of the people could cause deep conflicts within the community when not all groups are represented in the processes and when the number of participants are increased sharing could get ambiguous and troublesome (Rogers, *et al.*, 2008).

The levels of participation are summarized by various studies as 'A Ladder of Citizen Participation' or typology of participation (Arnstein, 1969). However, all recognize that there are various dimensions, spaces, degrees and levels of participation. The typology of participation (shown in the table 5.1 below) positions participation on a seven step ladder and gives direction as to the nature of participation and how the idea changes as a participatory process ranging from manipulation to self-mobilization.

Table 5.1: Typology of participation (Arnstein, 1969)

Level	Characteristics of each type
1. Passive participation	People participate by being told what is going to happen or has already happened. It is a unilateral announcement by leaders or project management without listening to people's responses or even asking their opinion
2. Participation in information giving	People participate by answering questions posed by extractive researches using questionnaire surveys or similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared or checked for accuracy
3. Participation by consultation	People participate by being consulted, and external people listen to views. These external professionals define both problems and solutions and may modify these in light of people's responses. Such a consultative process does not concede any share in decision-making and professionals are under no obligation to take on board people's views
4. Participation for material incentives	People participate by providing resources, for example labour, in return for food, cash or other material incentives. It is very common to see this called participation, yet people have no stake in prolonging activities when the incentives end
5. Functional participation	People participate by forming groups to meet predetermined objectives related to the project which can involve the development of promotion of externally initiated social organizations. Such involvement does not tend to occur at the early stages of project cycles or planning but rather after major decisions have been made. These institutions tend to be dependent or external initiators and facilitators but may become self-dependent
6. Interactive participation	People participate in joint analysis which leads to action plans and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structured learning processes. These groups take control over local decisions and so people have a stake in maintaining structures or practices
7. Self-mobilisation	People participate by taking initiatives independent of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need but retain control over how resources are used. Such self-initiated mobilisation and collective action may or may not challenge existing inequitable distributions of wealth and power

The table shows some gradient of shifting control over information, decision making, analysis and implementation awareness from a central, external agent towards those groups that have traditionally been marginalized and excluded from active participation in the development process, an anthropological concern. The typology of participation also highlights the shift in power over the process of development away from those who have traditionally defined the nature of the problem and how it may be addressed (by outsiders) to the people impacted by the issue. On top of the table, degrees of participation involve a transformation of the

traditional development approach towards the enhancement of the capabilities of the local people and communities to define and address their own needs and aspirations. Participation recognizes the importance of involving all stakeholders. How effective participatory processes are in bringing the voices into development processes and whether doing so is an effective and sure way of increasing the capacity of the people to define their future in collaboration with stakeholders.

Community involvement in health priority setting is an approach utilized by the private sector and the government which is increasingly focusing on the partnerships between the community and the government seen in the move from centralised to regionalised models including community-based grass root service delivery. The importance of engaging the community in fair priority setting is described as the four conditions in the “Accountability for Reasonableness” approach, used as a theoretical framework by this study, demonstrated in various studies (Gibson, *et al.*, 2005 and Martin, *et al.*, 2002) and discussed in Chapter Two. The conditions include relevance, transparency/publicity, appeals/revision and leadership/enforcement.

Firstly, relevance is where priorities are arrived at on the basis of reason like evidence or principles and that the priorities reflect the wishes and the feelings of the community. This study found that most of the health priorities identified at the community-based organizations and the structures in the public health sector were all relevant to the needs and wishes of the community. The worry which was found by this study was on actualization of the priorities identified. Resources for the realizations of the priorities identified were noted to be with the government and the community-based organizations themselves and not by the community which were found to be the last to decide on which priorities to be implemented.

Secondly, the priorities and their rationales should be transparent and made publicly accessible to all the stakeholders. This is where after deliberating on the various options/priorities identified, justifications for whichever option agreed upon should be clear and agreeable to the community. In many instances, this study found that the manner in which health priorities were made in the various health committees was not transparent as the agenda in various stages where the community was involved. Justifications for whichever priorities arrived at were not clear either as community representatives in the various structures were not able (not empowered) to demand for the same and or that the leaders were deliberately pushing their agenda and therefore decided not to divulge their rationales for choice of priorities.

Thirdly, revision means that there should be opportunities and or avenues to revisit and revise priorities in light of further evidence or arguments, and there should be a mechanism for challenge and dispute resolution. As discussed in Chapter Four, this study found that the community was getting opportunities to revise their health priorities mainly in the Non-governmental organizations unlike in the public health facilities.

Lastly, the leadership/enforcement ensures that the first three conditions are actualized. This study found that the community through their representatives either at the NGO the various committee levels did not have mechanisms of ensuring that their priorities are implemented. It is the NGOs and the leadership of the committees that were found to be involved in the ranking and final decision on the priorities to be implemented. Ranking allows positioning the selected priority issues in 'ascending' or 'descending' order of importance, in relation to specific (predefined) criteria. While ranking the identified health priorities, transparency and inclusiveness need to be ensured.

Although there is no universally agreed set of decision-making rules for setting health priorities some studies (Reeves, *et al.*, 1984; Hanlon, *et al.*, 1984) have summarized the ranking techniques often used in priority setting as follows:

Comparison in pairs: This technique allows focusing on two priority issues at a time. Each issue is weighed against another issue. In weighing the issues the person doing the ranking is requested to decide which issue of the two is the most important.

Anchored rating scale: This technique uses a continuous lineal scale from 0 to 1. Each scale value is associated to a level of importance, such as extremely important, very important, important, not very important and to be ignored. Rating of each priority issue is done by means of the scale.

Hanlon method: Under this method the rating of priority issues is calculated through the formula $(A + B)C \times D$, which integrates the magnitude of the problem, severity of the problem and effectiveness of the solution.

- **A: Magnitude of the problem.** This is the number of people affected by the problem, in relation to the total population.
- **B: Severity of the problem.** This takes into consideration the mortality, morbidity and incapacity rates, as well as the resulting financial costs.
- **C: Effectiveness of the solution.** This addresses the issue of whether current resources and technology are able to generate a specific impact on the given problem.

This study found that whereas many NGOs were using many of the described techniques especially passive participation, participation consultation, participation for material incentives and interactive participation, government health facilities were mainly adopting passive participation and participation by consultation and in some situations interactive participation was also used. This was because managers and staff in primary health care partnerships in local catchments, particularly in regional areas, are periodically required to work collaboratively to set health priorities.

This chapter concludes that health priority setting in the study area is characterized by passive involvement and participation of all the groups in the community as seen in the composition of the health committees from the district to the village level. Thus, current health priority concerns do not carry the wishes and feelings of the majority of groups in the community. This is against the spirit and the overall goal of decentralization approach of incorporating community participation in determining own health priorities as stipulated in the health sector reforms introduced in 2005. The chapter has also indicated that the various stakeholders operating in the study area adopt their health priority concerns/agendas and only have the community to endorse them thus denying the community an opportunity to identify and drive their own health priority concerns. Chapter Six describes the factors influencing health priority setting at the community level in the study area.

CHAPTER SIX

FACTORS INFLUENCING HEALTH PRIORITY SETTING AT THE COMMUNITY LEVEL

6.1 Introduction

This Chapter describes factors that were found to influence health priority setting at the community level in Magarini division. The factors emanate from within and outside the health facilities themselves. This study results showed that HIV/AIDS, TB, malaria and diarrheal diseases were the main health concerns in the area of study. Indeed, the four diseases are the leading causes of morbidity and mortality in Kenya. The diseases have serious impact on the general population especially women and children mainly due to underlying socio-cultural issues. The government of Kenya like other developing nations has stepped up measures towards combating the three diseases, among other diseases, as laid down in the millennium development goal number six.

6.2 Socio - Cultural Beliefs and Practices

Every community has its own beliefs and practices concerning health and diseases but each has peculiar ways of doing things. The practices and beliefs embedded in culture have some influence in people's perception, attitude and the overall management of diseases and other health related issues. However, some of the practices have continued to remain static despite numerous changes as a result of socio-economic, political and technological advances, among other issues.

This study found that illiteracy and cultural practices are the main challenges faced by the NGOs in their attempts to deliver health services in the district as observed by one respondent:

The main issues affecting our efforts in attempting to deliver health services to people in the community is cultural issues and a high number of people who do not know how to read and write (KI, male, 45 years).

Indeed, the cultural backgrounds and, by extension, the practices of a people has an important influence on many aspects of people's lives, including their beliefs, behaviour, perceptions, emotions, religion, rituals, diet and attitudes to illness, all of which may have important implications for health and health care (Helman, 2007). It is worth noting that not all cultural practices and beliefs are harmful, there are others that promote health as well as those that are harmful to human health. Arising from this, a lot of time and resources were noted from the interviews to be wasted in trying to explain issues to the community because of what was considered as low awareness and knowledge of new approaches. This has some effect on the community belief system. For instance, this study found that many people in the community do not believe in condom use, as noted by one informant:

Our great parents never used any protection and yet they lived well and happily even with many wives (KI, female, 38 years).

This study found that men in Magarini are allowed by the Giriama traditions to marry up-to four wives depending on one's' capability as observed by one respondent:

Another hurdle we encounter is a traditional expectation that Wagiriama men are allowed to marry more than wife (KI, male, 44 years).

As a societal expectation and a practice the traditions does not give room especially to the girls who could be young in age to express their own priorities including whether to marry or not. And because of the wide gap in age between husband and wife coupled with lack of

education young married girls are not in a position to negotiate to have or not to have sex, use condom to protect themselves against pregnancies, to decide on when to get pregnant or decide between fulfilling the traditions at the expense of health. Such practices may be responsible for health complications amongst young girls who become mothers immediately and perpetuating the spread of infectious diseases such as HIV/AIDS and other sexually transmitted diseases, among other consequences. One participant added:

Traditional beliefs are still strong. People still belief on herbs or traditional medicine. Initially, they used to associate HIV/AIDS with witchcraft and it has been really difficult to convince a population like that unless you first sensitize them thoroughly. Overall, culture is still a bottleneck in these areas due largely to illiteracy (KI, male, 47 years).

The cultural beliefs and practices coupled with high levels of illiteracy are some of the aspects in society influencing health priority setting in Magarini division. This finding was supported by another study which identified traditions and local cultures as issues influencing the process of priority setting in the entire district (Bukachi, *et al.*, 2013). For instance, in as much as various NGOs were trying to sensitize the community on the importance of having good sanitation facilities like latrines they were reported to be encountering problems because the community finds it difficult to share the same between children, old members and even together with the in-laws. The community has not seen any need to construct latrines. The problem could be because the need to have latrines did not come from the community but from the NGOs' perspective whose goal was not necessarily shared by the community. For sensitization programs like those to bear fruits, the community can be involved at the initial stages so that they can make their priority concerns known to the NGOs and therefore participate in advancing feasible approaches towards meeting their health problems.

Further, this study found that religion is an important attribute of the individual which may have tremendous bearing on the health of the people. Cases of certain individuals being followers of sects like *Imani moja* (one faith) which do not believe in seeking medical services in health facilities were mentioned by many participants. Other members of the community were reported to have their health priorities catered for by *waganga wa kienyeji* (traditional doctors) and traditional birth attendants who were noted to be visited by many people in the community because they believe in them. Religion has a bearing on the socio-cultural patterns of living involving age old habits, customs and traditions affecting cleanliness, eating, clothing, childcare and almost every detail of daily living.

Religious fundamentalism expressed through policy and funding decisions undermine progress towards achieving universal access to sexual reproductive health services. Conservative Christian attitudes towards sexuality in the United States, for instance, have led to government funding restrictions on services for sex workers, and the promotion of narrow sex education programmes for young people which focus only on abstinence as a means of STI prevention. The policies limit access to and information about contraceptives and safe abortions.

This study found that the existing priority structures at the community level do not carry the wishes of the community. It is from that lack of a priority concern that even many pregnant women were noted to be giving birth at their homes while others were reported to be dying from complications associated with pregnancy. Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for 80% of all maternal deaths include

severe bleeding (mostly bleeding after childbirth) and high blood pressure during pregnancy (pre-eclampsia and eclampsia), among others. This finding concurs with those from a study that noted that maternal mortality rates are significantly higher among vulnerable groups, particularly among the indigenous, ethnic or other minorities groups (Islam, *et al.*, 2010).

In addition, WHO findings shows that globally, approximately 800 women die from preventable causes related to pregnancy and childbirth every day with half of them occurring in low-resource settings. Improving maternal health is one of the eight Millennium Development Goals adopted by the international community in 2000. Many developing countries were not consulted in prioritizing their health concerns as development goals but taking advantage of its position globally, WHO had those countries committing to reducing maternal mortality by three quarters between 1990 and 2015 contained under MDG five. Although since 1990 maternal deaths worldwide have dropped by 47% a lot could have been achieved if the WHO member countries in the world participated and supported in developing and implementing specific strategies of reducing the deaths. In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990 (WHO, 2012). The high number of maternal deaths reflects inequities in many countries in accessing health services. Women in developing countries have, on average, many more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher.

The belief system is a factor which was found to be influencing health priority setting amongst communities living in rural areas. In fact, a study shows that the beliefs and practices of a community relating to ill health are central feature of the culture (Helman, 2007). This study found from the interviews that various organizations and institutions in partnership with some community based organizations have mounted programs aimed at sensitizing the

community on socio-cultural issues through various forums such as public *barazas*, drama and workshops organized in many places within the community. Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviors, the effectiveness of health promotion efforts, and access to, availability of, and quality of health care. Social and cultural factors also play a role in shaping perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being. In addition, such factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival, and mortality (Islam, *et al.*, 2010).

The findings of this study also concur with that of a study conducted in Nigeria that found out that cultural belief and practices of a people not only affect their health priority setting but also affect all their affairs including health and disease (Onyeabochukwu, 2007). Cultural practices like the ones described may eventually help in perpetuating and increasing the prevalence of some diseases as the community struggle to make their health priorities. Culture and religion can also affect communication, adherence to medication and family support.

6.3 Accessibility and Cost of Health Services

Many developing countries have had to struggle with issues such as accessibility, affordability, availability and, overall, the quality of services in an attempt to provide health services to their populations (World Bank, 1987; 2000). What exacerbates situations is an increase in expenditure that is mainly funded from public resources and the pressure which this has exerted on governments which are trying to control public spending.

Committing to provide free health services for all citizens in 1963 the Government of Kenya envisaged that a full range of heavily subsidized health services will be available to all the citizens (Owino and Abagi, 2000). The government, through the Ministry of Health, acknowledged that Kenyans continue to be overburdened by the out-of-pocket health financing while attempting to deal with the dilemma of combating a growing burden of disease, regulating quality and improving equity in health care distribution within the context of declining public financing (KNHA, 2005). The government, as reflected in the various reforms such as National Health Sector Strategic Plan 1999-2003, has shown its commitment to creating an enabling environment for the provision of sustainable quality health care which is acceptable, affordable and accessible to all Kenyans. The government arrived at that commitment based on its findings and recommendations that seemed not to have factored in the participation of the various groups at the community level.

Following health reforms in the Kenyan health sector, whose goal was to provide accessible, affordable and efficient health care services, the government introduced a way of sourcing funds from users, through the introduction of cost sharing. The overall goal of cost sharing in public health facilities was to improve the provision of quality health care services. It was envisaged that funds generated from user fees would supplement government's diminishing expenditure allocated to health care services, and therefore, would ensure continued provision of health care services. Though the approach was argued to have resulted in quality improvements such as more responsive emergency services, better availability of medicine, increased cleanliness, friendlier staff, increased motivation amongst staff and increased accountability, this study observed that the situation in many facilities in Magarini has not improved. The approach had a goal which reflected the feelings and interests of the

government and left out the feelings, values and the wishes of the diverse groups at the community level in as far as the issues put across was concerned.

The costs associated with the services provided in the facilities were of particular interest to the majority of the members in the community. This study found that though the cost sharing program was stopped, the same is not true with certain services such as those in the maternity.

One participant noted:

You have to pay 1,000 and 800 shillings in the night and in the day, respectively. The only receipt given there is for the 20 shillings for the book or card but not for the 1,000 or 800 shillings. If you buy even drips to be given to patients, drugs and even injections then it is better to close down the facility (FGD, female, 47 years).

Specifically, participants from FGDs mentioned that the services offered in the majority of the health facilities were charged ranging from drips, sleeping nets, cloths, cotton to drugs with no receipts in many health facilities. Through the health committees especially at the dispensary level, charges on services provided by government facilities was one of the sensitive issues which required realistic and practical approaches that take the feelings of the majority of the people at the community level into consideration. In such situations where money is involved, it is evident that the community was not and continued to be ignored in realizing their health priorities and decisions. Cases of patients being referred to specific chemists where drugs bearing government labels were sold were reported by many participants in the FGDs. This may mean that drugs meant for delivery to patients at the government facilities are either diverted just before they get to the facilities or taken out there from the facility stores.

The issue of charging services negates the overall goal of the health sector reforms in Kenya of providing accessible, affordable and efficient health care services to all Kenyans. The goal overlooked the fact that majority of the people living in rural areas in Kenya, including those living along the Coast region, are living below the poverty line. High levels of poverty and high cost of life has made many people at the community level unable to make and meet their health priorities as other aspects of life compete for the meager resources. This has seen many groups at the community level such as Waata marginalized and vulnerable in accessing healthcare.

Some of the practices described may amount to corruption, breach of ethics and is therefore against government regulations. In this regard and with a view to eradicating the practices, service provision in the facilities is spelt out in the Service Charter that emphasize, among other things, that official receipts should be provided for any transaction where money is involved. This finding is similar to what Gibbons (2008) and Reis, *et al.*, (2005) found in their respective studies. This could further be attributed to the declining health sector expenditure, inadequate management skills at the district level, over centralized decision making, worsening poverty levels and increased burden of diseases as reported by the Kenya Service Provision Assessment Report of 2004.

Accessibility of health facilities in Magarini was found to be one of the areas which had not been given the prominence it deserve in the priority areas at the community level. One respondent noted:

There are very few health facilities existing in this part of the country especially those within the community (KI, female, 44 years).

The facilities were found to be too far from each other. An attempt has been made, as a matter of a political priority, by decisions to construct dispensaries within the community using funds from the CDF in areas like Chamari, Mtoroni and Gongoni. The idea of constructing the facilities was concluded by CDF officials without consulting the community or its representatives as a way of rewarding communities in areas which were considered loyal to current political leadership. Over time, some constructions which had been completed and earmarked to operate as dispensaries had not been equipped as agreed in a gentleman agreement between representatives of both the CDF and the Ministry of Health where the former would construct structures while the government would provide equipment, personnel and drugs.

Another element influencing accessibility of health services is the road network which was found and identified by participants and respondents as generally poor. One participant observed:

The state of our roads in this area is seriously unbearable during all the seasons (FGD, male, 48 years).

The roads which pass through bushy hills and mainly earthen and poorly maintained were problematic to pass during rainy seasons as bridges and some sections of the roads were reported to be washed away. Again, political considerations are considered in prioritizing roads for repair and maintenance. This study found that the people in charge of roads did not consult or seek the views and opinions of the community in identifying roads to be repaired. The public transport that serves the study area and link the hinterland to Malindi district hospital was noted to be charging between a hundred and fifty shillings (150) and two hundred shillings (200) during dry and rainy seasons. The charges were found to be out of reach for many people in the study area as they were not involved in arriving at that decision.

This has subjected many people especially the sick to untold pain and suffering and death. This in itself was found to have limited the community to some priority options.

Another way of enabling the community to access the health facilities in some areas was the decision by the area Member of Parliament to donate a reconditioned vehicle with private registration numbers as an ambulance without giving priority to the people in the community to decide on the issue. In that arrangement, this study found that the community was made to pay 3,000 shillings for that service per use to any destination within the division. That service was abandoned by the community because majority of the people could not afford to pay for the service.

Arising from the inaccessibility of health facilities, this study found that many pregnant women, children, disabled, the old and the elderly were reported to be the most affected population in trying to access the facilities and by extension the health services provided thereon. In many instances many groups, for instance, pregnant and lactating women were reported not to be attending to the ante-natal clinics and or the maternal child health services.

A respondent noted:

From the bad roads in this region, many people especially pregnant women, children and *wazee* have difficulties in accessing services in our health centers. Pregnant women have had to deliver anywhere (KI, male, 49 years).

As a consequence, this study found that cases of women giving birth at home, in the bushes or along the roads, among other places, with the assistance of community health workers, traditional birth attendants or other women were reported to be high. This was noted as a serious issue which had subjected many of them to severe pains which may have led to child or maternal deaths due to complications associated with delivery. That finding does not go

well with the goal of The Vision 2030 of providing equitable and affordable quality health services to all Kenyans and reducing health inequalities (KV, 2030).

Economic factors and social inequality are some of the most important causes of ill health since poverty may result in poor nutrition, overcrowded living conditions, inadequate clothing, low levels of education, housing as well as exposure to physical and psychological violence and stress, drug and alcohol abuse (Helman, 2007). The unequal distribution of wealth and resources and of access to health care facilities can also lead to this situation. The disparities in the distribution of health facilities in the entire Coast region are not informed by disease burden but economic and political considerations.

6.4 Attitude and Practices of the Health Workers

This study found that services provided in many health facilities were far below the expectations, feelings and wishes of the community in many aspects mainly as a result of the attitude and practices of the health providers. Focus group discussions showed that the services provided at the health facilities were not good due to the unavailability of drugs, shortage of staff and the general attitude of the health personnel. One participant observed:

It is not a joke that things are terribly bad there. Somebody is busy with stories and yet patients are there in the queue awaiting for the treatment (FGD, men, 54 years).

The issue of how and when the community should be served by the health personnel is a concern to health priority setting at the community level. The concerns of the community regarding the attitude and the general behaviour of the health providers was expected to be addressed in the structures at the lower level such as the DHMB/T and facility committee where the community is represented. The ultimate goal of those structures is to provide an

opportunity for the community to participate in identifying and addressing bottlenecks such as the attitude of health providers which can intimidate the community or patients from accessing and receiving better health services and information.

The reported cases that border on the attitude of the health providers is an indication that the community has not been shown that it is within their basic right to receive better health services including information on various health issues and has not participated in making informed priorities. But where attempts to participate in raising their concerns and by making priorities had been made, most participants reported that they had not been listened to by the relevant committees, as stated by one participant:

Watu duni kama sisi hatuwezi kwenda pale kwao tusikizwe! Hutasikizwi na mtu (poor people like us cannot just go there and be listened to. You will not be listened to by anyone) (FGD, women, 44 years).

The following descriptions were examples which illustrate that patients/community have not been informed of what they should do about the attitude of the health providers whenever they visit health facilities. A doctor was reported to have a habit of 'coming and reading newspapers instead of treating patients until a patient died at the facility'. The same was also noted of another doctor who was giving prescriptions to patients without thorough investigations:

Even before you sat down to explain what took you there, he could prescribe *mbili sasa, mbili jioni* (two now, two in the evening) till he was nicknamed *mbili sasa, mbili jioni!* Before you sat down to explain yourself he was through with you *mbili sasa, mbili jioni!* (FGD, women, 38 years).

This study found that at a health facility, health personnel living within the staff quarters would go out of the facility for breakfast at about eight to nine o'clock instead of attending to patients who arrived at the facility as early as six in the morning subjecting patients to more

suffering and pain in the queues. In the absence of the health personnel, instances where support staff (cleaners, grounds-men/women and or watchmen) were attending to patients when the nurses were out for lunch, in the evenings or in the nights in certain facilities were reported. One participant stated:

You see we call everyone in white coat *dakitari* (doctor/nurse). If the real *dakitari* has not come or is not coming, we will not know but you will not miss to get services. Prescriptions will be done by anyone there including getting drugs (FGD, female, 52 years).

As a result of the unfriendly attitude, practices and even the language used by health providers, the study found that women in the community did not take their children to the health facilities. In addition, cases of nurses disclosing medical conditions of their patients especially in the Voluntary Counseling and Testing and maternity clinics were also reported by majority of the participants in the FGDs. It was stated:

If you are found to be HIV positive, that information will be given out by the nurses. They say, *mwone fulani, amepatikana yule!* (look at so and so, he/she has been infected), there is a lot of fear at the hospital. Even when you go to the maternity, the nurses will announce how you look like ...*aaah usimwone yule anavyovaa, hata hanyoi!* (do not look at how that one is dressed, she does not shave) (FGD, female, 49 years).

Comparatively, the study found that there are differences between the services provided at the District Hospital in Malindi on the one hand and the health centers/dispensaries on the other hand. Availability of drugs, the general attitude of the staff personnel, management and care of patients are some of the attributes of the district facility. One participant stated:

But here (at the health center) we are treated just like dogs. Things are even worse if you are pregnant. You are ordered including being physically pushed to go here and there. You are shown directions *kwa madharau zaidi* (with a lot of malice) as if you have seriously offended someone. *Yani kuongea na wewe wanafikiri ni sumu. Waonyeshwa kupanda kitanda kwa vidole* (you are shown to get into bed by a finger). But if you give out money, ooh services will be better for you! (FGD, men, 39 years).

The consequence of the situations like those described has seen most people in the community having their priorities missed to be recognized and addressed and even losing faith and confidence in both the personnel and the facilities and are instead suffering from various ailments which could otherwise be treated easily and freely at the government facilities and only visit them when their conditions deteriorate, as a last option. That finding is similar to what have been reported by CDC (2006) and Gibbons (2008) who identified the attitudes of health professionals as a barrier to utilization of health services and therefore emphasize on adherence of ethics and by extension the general code of conduct.

Trust, non-judgmental and respect are the main ethical principles that play a crucial role in as far as the nurse/doctor-patient relationship is concerned and which also influence utilization of health services. These are very important in self-regulated professions in order that both those who practice the professions and those whom they seek to serve have no doubts what represents proper practice and where the boundaries between proper and improper behaviour. The mere fact that the health staffs are employees of the government is not a guarantee that they offer better and good services to the community. Their practices depict them as incompetent, corrupt, lazy or simply officers who are disinterested with their work.

This finding is also similar to another study done in Nigeriathat showed that despite the lack of resources, discriminatory behavior and attitudes toward patients suffering from certain ailments such as HIV/AIDS exist among a significant proportion of health-care professionals (Reis, *et al.*, 2005). It is from this that the services of traditional birth attendants, herbalists and other stakeholders in the health sector such as the World Vision and Kenya Red Cross, among other institutions, have penetrated and found a basis for being in the community.

From the attitudes and practices of the health care providers described, it is evident that the consumers of services in health facilities at the community level have either not had their priority concerns, in as far as specific services needed and the customer relations is concerned, communicated to the health managers or that the managers have continued to ignore involving them in health priority settings processes. There are various groups at the community level who ordinarily utilize services at the health facilities that are distributed within the community. The groups that include the young, adolescents, women, old and elderly, among other members of the community, have not had an opportunity to participate in forums with the health managers to raise their priority areas and how the priorities could best be communicated using strategies that are friendly, easy and practical to the majority.

The attitudes of the health providers influence the decisions of the community to accept or not accept service(s) from the facilities, a practice which can subsequently make the consumers to make other decisions like seeking services elsewhere. Many members of the community who were either illiterate or semi-literate were reported to be feeling less empowered in terms of knowing their basic rights and therefore feared to push or communicate grievances. People with low-level reading skills may suffer from health problems because of their inability to read medical directions, health-related literature or prescription labels. Chronic health conditions may go improperly monitored by patients who are functionally illiterate and their overall well-being may worsen overtime causing frequent doctor or emergency room visits, hospitalization, or even death.

Whether people at the community level are literate, illiterate, poor or rich, the right to health is fundamental to the physical and mental well-being of all individuals and is a necessary condition for the exercise of other human rights including the pursuit of an adequate standard

of living. Indeed health is fundamental to enjoyment of the right to life, and the right to a healthy life is fundamental to all other constitutional guarantees.

Data from FGDs showed that participants had lots of reservations and were very reluctant to discuss services provided at the health facility. In many instances they were seen checking sides to confirm that nobody from the staff working there was listening to what they were conveying. This was a clear indication that all was not good in as far as provision of health services there was concerned. Whenever participants were given a clue of some of the services not provided well, they could laugh their hearts out while nodding. In most instances, many participants who believed that the researcher was an official sent by the headquarters of the ministry concerned and were heard remarking that the staff had been caught unawares especially in occasions where services were offered very late and poorly.

6.5 Priorities of Non-Governmental Organizations

The Government of Kenya, through the Ministries of Medical Services and Public Health and Sanitation has been the main provider of biomedical health care in Kenya for a long time. However, its service delivery system has been boosted by donors, international aid and faith-based organizations, among others. According to Bukachi, *et al.*, (2013) agendas of such agencies influence priority setting processes in the then Malindi district in general.

This study found that there are many international organizations and institutions such as USAID, World Vision and Kenya Red Cross, among other organizations, which operate and drive own health agenda in Magarini district, as development partners with the government of Kenya and which draw their health priorities from own baseline reports but link them to guidelines, policies or general reports from the two line ministries in charge of health.

Overall, they all partner in developing and running health priority concerns such as HIV/AIDS, malaria, tuberculosis, home-based care for PLWHA, water, sanitation and livelihood, among other priorities. One informant noted:

We used to do community mobilization supporting MOH efforts and linking its structures with other development partners, health facilities and facilitate referrals, provide sleeping nets and water pipes (KI, male, 44 years).

From the year 2008 to 2010 USAID, through the Aphia II program, gave small grants of between 10,000 and 20,000 shillings to groups like women, village health committees and Community Health Workers for either goat or poultry keeping or water projects and for small scale farming for some income as a way of building their capacity. This was a development priority reached out based on own assessment on the community needs which did not necessarily reflect the immediate priority concern of the community. At the expiry of the Aphia II program, Aphia Plus program was introduced with interests in livelihood programs under what it called Criteria four. This was also based on reports from the previous program but which missed to incorporate the community at the onset. Under the program, this study found that representatives of the program identified the following priority areas, on their own, sensitizing the community on various health programs such as HIV/AIDS, malaria, nutrition, farming, food distribution, water, immunization and livelihood programs, among others, as noted by one informant:

We sensitize them in many occasions through women and youth groups. We have two *barazas* per month and health messages have to be communicated. According to our service charter, it is a must to communicate health messages to the community (KI, female, 46 years).

In order to realize their priorities, most NGOs and institutions were noted to have identified and trained various players such as herbalists, traditional circumcisers together with the TBAs in health and livelihood matters with a view to assist in health education (such as sensitizing

women and ensure that all deliveries are done at the facilities and in reducing child mortality) and link them to health facilities. This finding is in line with the Ministry of Health recommendation that resource persons should be elected from the community structures to be trained to effectively manage and participate in health activities (MOH, 2006). There were also CHWs who were noted to be assisting the community in many aspects, as one informant added:

We have community health workers in every village who normally volunteer and whenever there are outbreaks of diseases they really assist in distributing drugs to the community and if some drugs are need to be taken to boreholes they also take them (KI, female, 40 years).

In as much as the organizations and institutions would wish to involve the community in most of the stages in making priorities and decision making, the major share in power is vested in them and they have a say in the processes and more-often, their opinion was always influential especially at the implementation stage. The organizations were also well versed in the project and have a high level of understanding of all the components and the expected outcomes. Implementation is based on collaboration which is built on relationships with various groups of beneficiaries. However, the challenge in such collaborations is that every group or player in collaboration is holding different levels of power which has varying levels of influence on the priority settings. This was a perspective of the various NGOs and institutions which have had to come up ostensibly to rescue communities from the jaws of misery and poverty. In its place, community perspective of health was relegated to the periphery.

As communities respond to the multiple factors involved in various health issues, all parties will have to sort out their roles and responsibilities hence after-all improving health is a shared responsibility of health care providers, public health officials and a variety of other actors in the community who can contribute to the well-being of individuals and populations.

Illiteracy and cultural practices are the main challenges faced by the organizations working in the study area in their attempts to deliver services in the district. In such contexts, participation is a concept that is not easily accepted or practiced. Participation in such a community does not necessarily fascinate people especially in the rural areas where the practices are deep rooted. This has made some people to be either slow, reluctant or totally loose interests in participating in any activity. Participation therefore may seem to be irrelevant to their issues.

Participation of people in rural communities where illiteracy levels are high may be associated with low levels of awareness of issues. Taking advantage of this are leaders or other groups whose aim is to monopolize and assert their ways in as far as priority setting and decision making processes are concerned. Majority of the populations in the rural areas like Magarini lack resources that include adequate information, appropriate contacts, money and often time for effective participation. In addition, the norms and expectations of women restrict their ability to participate in any meaningful activity including priority setting and decision making over community resources. Therefore, women suffer at the hands of their overwhelming responsibility for household and child bearing tasks.

6.6 Prevalence and Burden of Diseases

This study found that there are many diseases affecting the community in Magarini and Coast region in general which include HIV/AIDs, Tuberculosis, malaria and other disease conditions as indicated in Chapter Three. The Ministry of Health has put forward several priority areas based on its own indicators established from databases obtained from health facilities, outputs from partners and systems which do not reflect the wishes and the concerns of the community. The priority areas emanate from the prevalence and burden of diseases affecting people. This has resulted in health systems and programs that have been implemented at the community level. The community which is the main consumer of the systems and programs has not been involved in developing best approaches towards the realization of the priority areas. The opportunity to involve and make the community participate and contribute in identifying priority concerns which carry their felt needs, wishes, values and the feasible methodologies of mounting the same may have been missed out.

Despite the various efforts by the Ministry of Health and other development partners both malaria and HIV have been noted to be killer diseases in the Coast region. In particular, HIV/AIDs is common especially among adults aged between 15 and 64 years in the rural and urban population, affecting 5.4% and 11.1%, respectively in 2009 (NASCO, 2009). This puts the diseases as both community and public health concern in the region in general.

This study found that the prevalence of HIV was attributed to young girls and women mainly from outside Coast region and even from neighboring countries such as Tanzania, Uganda and Democratic Republic of Congo flock to the Kenyan Coast especially to social and other strategic points such as hotels, restaurants, beaches or even homes in areas like Watamu/Gede, Malindi, Gongoni and Marereni during high tourist seasons. Over time, local

residents, especially young girls and men of ages between 15 and 24 years who have had to work as tour guides have had to enter either into prostitution and or male sex work (locally referred to as *ushoga*) with some of them abandoning their families in search of livelihood from tourists.

In search of employment opportunities or as a result of poor pay from the salt factories that are spread along the Malindi-Lamu coastline, this study found that there are many people living in cosmopolitan urban slums mushrooming around the factories who have had to engage themselves in prostitution neither to survive or just to top-up on poor pay. This has mainly exposed the youth to serious health risks. This finding concurs with evidence that Zulu, *et al.*, (2002) is showing in his study that the extreme deprivation that is associated with high unemployment and low wages of slums traps residents into engaging in risky sexual behaviour for economic survival. Studies by Gutymachern (1998), Ulin (1992), Carael and Allen (1995) and Zulu, *et al.*, (2002) and KDHS reports (1998; 2003) also found that the youth in slums report high sexual activity, have more sexual partners and low condom use which puts them at increased risk of infection with sexually transmitted infections including HIV and as well as unplanned pregnancies amongst girls, among other consequences.

Malaria also remains one of the public health concern still affecting children and women in the Coast region including Magarini division. This finding was confirmed by the health records from the district facility showing that malaria was one of the leading causes of outpatient morbidity among all the populations in the year 2009 (KNBS, 2010). The government and other key partners have been relying on the high prevalence of number of patients testing positive to malaria testing at the health facilities. The approach missed to provide the community an opportunity to convey its understanding and the perception of the

disease, one of the very important components in effective community based malaria control programs (Mwenesi, *et al.*, 1995) and the practical community-based methodologies of approaching malaria in totality. This was reflected in the recurrent outbreaks of malaria in the Coast region.

This study found that many people respect traditional healers because of their powers to treat multiple ailments especially fevers blamed on spirits, witchcraft and or sorcery. This has made many of them to trust that their priority concerns can best be addressed by the traditional healers. One respondent observed:

Waganga kutoka mbali kama Tanga wako huku na wanatibu kila ugonjwa hata malaria. Watu wanawaamini kwa kuwa wanatoa dawa za kutibu kila aina ya magonjwa (Herbalists from far places like Tanga are here and are treating every disease. People trust them because they give treatment for every ailment) (KI, male, 46 years).

In few situations where malaria is endemic, some form of self-treatment is usually common either the use of traditional home remedies or of pharmaceutical drugs bought from a retail outlet. The strategy is partly as a result of high costs of medically prescribed drugs but also from cultural beliefs regarding the origin and nature of the disease itself. Whichever the belief, sick people may be treated first at home (Mwenesi, *et al.*, 1995) or taken straight to a hospital or at times to a traditional healer (Winch, *et al.*, 1996).

At the community level, this study found that none of the many groups in the community have been incorporated into participating in reaching out to priority areas that are geared towards controlling or alleviating the spread and effects of the diseases.

6.7 The Role of Health Committee and Community Leadership

The establishment of the District Health Management Boards and the District Health Management Teams, which host health committees, was a deliberate effort to allow greater participation of the community in the management of health service delivery and to strengthen the implementation of activities at those levels (MOH, 2006). Together, the DHMB/T provide management and supervision support to rural health facilities (sub-district hospitals, health centers and dispensaries).

In constituting the teams to the health facilities, this study found from majority of the participants in the focus group discussions that politics is a key determinant to the appointment of members of the community to the health committees. This was pointed out as a way of rewarding loyal friends of politicians or other people in authority like the chairmen of health committees or doctors in-charge of hospitals. One respondent observed:

The local administration usually organizes for those appointments in cahoot with few friendly individuals and just select themselves (KI, female, 50 years).

This was supported by responses from many participants in a different way by arguments that if the community could have been involved in the selection/appointment process, problems associated with service provision and utilization of the same could not have been there. In that regard, this study found that the services provided in many facilities do not represent the wishes of the community. That line of thought was disputed by some respondents pointing out that the community was involved in the elections and appointment of its members to health committees as a matter of policy. The committee also communicates its activities and priorities through Chief *barazas* whenever they are invited as noted by one respondent:

We have leaders meetings organized by the Chief for all activities done within his location. That is where we air our programs and we try to solve where there is a problem and try to resolve it (KI, male, 54 years).

The scenario depicts a clear lack of democratic practices in the processes described. In areas and communities where participatory approaches have been attempted and seen to work, though slowly, members understand that they have some role to play in priority setting and decision making processes in choosing their own representatives and even further know that their opinion(s) can influence change. It is very rare in communities mainly in rural areas (like in the study area where general awareness on the basic rights is minimal) to vote for individuals based on their own conscience but more-often influenced by leaders or social groups. The general lack of democratic practices detach members of a community from participating in their rights and in the process assists in creating an environment that lacks the basic values in democracy such as trust, credibility and accountability.

While decision makers struggle to set priorities appropriately, this study found that community leadership does not lay emphasis on priorities of the all the groups in the community often taking advantage of ignorance and or levels in understanding issues. One participant observed:

Majority of the community leaders have no vision or action points whenever they seek for votes. In most situations, their minds are pre-occupied with planning for acquiring materials for themselves or busy pretending to know the issues facing the community (FGD, male, 56 years).

This study found from key informants that leadership (*uongozi*) to the majority of the members of the community is seen as the engine that guide, provide direction and an act of embracing people's ideas and reaching consensus. In other studies with similar findings, leadership has been shown to carry heavy burden of responsibility where priority setting is

one of the reasons making leadership a major challenge and one of the easiest to get wrong (D'Souza, 2007). Decision makers as leaders are sometimes at a crossroad because they do not have explicit framework for priority setting and are thus 'frustrated' (Mitton and Donaldson, 2003).

The main role of community leadership is to provide overall guidance and influence regarding priority setting and making decisions that may lead to enhancement of social and health development in the community. The leaders also act as agents of communication between the community and the local provincial administration representing the central government. In choosing leaders at the community level, specific characteristics such as the level of education, among others are considered as a benchmark to developing negotiation skills and subsequently trigger social and health development. Level of education is viewed at the community as an important aspect in leadership which is associated with successes, as stated by a respondent:

We elected our Member of Parliament based on education among other characteristics because an educated person will be able to express himself in parliament and be able to drive the agenda of the community well. In the eyes of the people he can deliver...If you are not highly educated, you may not have the competence to make decisions and therefore people can decide to ignore what you have said (KI, female, 32 years).

But some of the socio-demographic characteristics such as age, religion and ethnicity gender are aspects of leadership in the community which were found not to matter. Though gender was not found as a major issue in community leadership, this study found that women involvement and participation in health priority setting and decision making is largely limited by socio-cultural issues. Instead, their inputs were found to be required in social issues such as marriage negotiations, midwifery, child education and a big role in child health and the general upbringing.

The Provincial administration is another position that was found to be playing a pivotal role in providing the necessary linkage between the community and all the stakeholders in the health sector, among other activities. It is also mobilizing the community for the various stakeholders in an attempt to make them participate in advocacy programs such as HIV/AIDS, nutrition, immunization and malaria in ensuring that better healthcare services are taken closer to the community within their areas of jurisdictions, as observed by one respondent:

We ensure that proper working relations between the community and development partners are given the right forum. We bring everyone on board even at the onset of activities such as sensitization against killer diseases after consultations with representatives of the line ministries (KI, male, 51 years).

The Provincial administration partner with major stakeholders in health sector at the community level such as government of Kenya line ministries, community-based organizations and individuals in ensuring that better health services are taken closer to the community within their areas of jurisdictions. Through such initiatives and partnership with APHIA Plus and Lishe Bora from the Ministry of Health, this study found that provincial administration calls for public meetings and participate in sensitizing the community on HIV/AIDS, nutrition, immunization and malaria, at times through women and youth groups.

As part of the Rapid Response Initiative program, this study found that the local provincial administration also provide forums for monthly meetings at the location level with local leaders, representatives of government ministries, NGOs and religious leaders, TBAs, school heads, herbalists, youth and women, traditional circumcisers and village headmen. The importance of such forums was noted to be mainly to identify and or communicate health priorities to authorities at higher levels. Provincial administration has also adopted a system of getting / receiving the concerns of the people through what is referred to as Mobile Complaint

boxes which are always carried to public meetings and well placed in the gatherings. One respondent observed:

We have the new *baraza* model of running the *barazas* where our speech does not mark the end of the meetings. We don't close meetings without giving an opportunity to contribute or say something they may be having. We want to know their involvement in those issues and more-often they get time to say how they want certain issues be done (KI, male, 49 years).

The approach of involving the community directly used by the provincial administration, unlike the approaches employed by NGOs that uses CHWs and TBAs, was a step whose aim was to intentionally create open forums where interactions between them and the communities over certain issues occur. Dealing directly with the community present an opportunity to the provincial administration to either exchange outcomes of meetings realized from other levels above and convey other communications in form of policies, guidelines and emerging issues from government departments and other stakeholders.

In conclusion, the findings in this chapter shows that several factors such as socio-cultural beliefs and practices, accessibility and cost of health services, attitude and practices of health workers, priorities of Non-governmental organizations, prevalence and burden of diseases and the role of health committees and community leadership influence health priority setting in the study area. The study has also shown that illiteracy and poverty are other factors that influence health priority setting in the community. Members of the community who were illiterate, semi-literate or poor were noted to be powerless and not knowledgeable of their basic rights thus making them unable to effectively push or raise their health priority concerns, even if they are given an opportunity.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The main objective of this study was to explore community participation in health priority setting. Specifically, the study set out to assess the health priority setting processes at the community level, determine the level of community participation in health priority setting and to establish factors that influence health priority setting at the community level in Magarini division. This chapter presents conclusions and recommendations of the study.

7.2 Summary and Conclusions

From the findings, the study has showed that there are three processes of health priority setting depending on the various institutions existing at the community level. The study found out that health priority setting processes include priorities identified by institutions and organizations, invitation of the community by those institutions to deliberate and reach an agreement often through consensus based on the priority concerns of the institutions. The study has further shown that the processes are tedious and vigorous that range from making a balance between determining the health needs, giving their justifications, on the one hand, and demands of the majority of all the groups in the community, on the other hand, in the context of competing interests.

The study findings have described the many approaches used by the various stakeholders in the community in their attempt to make priorities viable and relevant to the needs and wishes of the majority of the groups within the community. Though they vary in the processes used, their aim has been to provide some forums to the community in order to participate by providing own ideas and perspectives which carry the felt needs and wishes of the majority of

the members. In involving the community in health priority setting and generally decision making and resource allocation, as emphasized in the KNHSSP II, the contribution of all groups in the community was deemed necessary as a way of reducing existing health inequalities (Muga, *et al.*, 2005). This is also a way of improving the legitimacy and fairness of health priority setting processes (Bukachi, *et al.*, 2013).

The study findings has also shown that there is a relatively low degree of community influence or control over organizations in which the community members participate and what the community members go through is an empty ritual of participation with no real power needed to influence the outcome of any process. The community is still not actively involved in health priority setting and the overall decision making processes in the study area. But where the community is involved, the level of involvement and participation in community structures is vague compared to their participation in the various activities of health development partners operating within the community, which is very high.

In government related structures such as the DHMT and both the health center and village health committees, community involvement and participation in health priority setting was found to be ambiguous. As far as the composition or formation of health committees is concerned, the study has further showed that the criteria for selecting representatives of the community is not clear to the community and therefore the community does not understand the motive and the essence of the committees. The study also showed that the community is neither involved nor does it participate in the selection of committee members. Influential people such as the DMOH, councillors or the local provincial administration were found to pick people who are loyal to them.

The study findings have also demonstrated that there is a disconnect between the MOH guidelines and the actual reality at the community level where poverty and illiteracy levels are high and where election to the committees is based on socio-economic and political backgrounds and not on expertise. The study has also shown that there is a disconnect between the national policies and actualizing the same at the community level. The government did not have sufficient resources to support the full implementation of policies and in some cases the policies were too unique and unrealistic to be achieved. In addition, some policies do not carry the feelings and wishes of the community, a reflection that the communities were not involved in the development and realization of the same. The study found that many of the government documents do not conform to the conditions of the AFR framework.

The study findings further showed that the health providers' attitudes and practices together with the socio-cultural issues are the main factors influencing health priority setting and the general provision and utilization of health services in Magarini. Though lack of essential services such as drugs and staff houses was found as some of the issues influencing and affecting the health service delivery, specific personal attitudes and practices of individual health workers and other staff working in the facilities (such as rudeness, unqualified, untrustworthy, malicious, uncaring, corruption practices, among others) are largely to blame for poor utilization of health services in many health facilities. This has made the community to resort to alternative ways of seeking health services. The roles of traditional birth attendants and herbalists have come up to fill the void left by formal health services.

It was also found that there are numerous challenges such as poverty, illiteracy and prevalence and burden of diseases such as HIV/AIDs, malaria, tuberculosis and anaemia which influence health priority setting. Poor road network was found to be another challenge affecting health priority setting in the study area. The many patients who would be transferred to the district facility at Malindi for further medical attention and care are left in great pains and suffering (including death) as a result of complications associated with their ailments as most facilities in the hinterland rely on one ambulance vehicle available and stationed at Malindi district hospital. Specifically, many pregnant and lactating women, children, disabled, the old and the elderly were found to have been unable to get their respective health needs met.

7.3 Recommendations

This study has touched on various core issues that are relevant to policy and programs and which are geared towards the realization of maximum involvement in all the stages in health priority setting processes and participation of the community in health priority settings at the community level. Arising from the study findings and discussion, the following recommendations can be made which will go a long way in enhancing community participation in health priority setting in general.

1. This study has shown that issues like publicity, relevance, leadership, are essential components that need to be factored in to ensure fair health priority setting at the community level. The outcome of such attributes is fairness, equity, trust and accountability in health priority setting and subsequently improved delivery of health services to all the groups in the community. The AFR framework should be embraced to bring out such issues especially at the community level where such attributes can

enhance community participation and subsequently lead to an improved utilization of services.

2. The government health system should recognize and incorporate the contribution of all groups of people at the community level in health priority setting by giving them more opportunities to participate. This will make the groups move away from being passive participants to active participants and contribute to issues that are touching on their health status thus making issues relevant. This will eventually see an empowered community which will be able to demand for its space and other rights in health priority setting in all its processes up-to and including the implementation.
3. With the aim of reducing mortality cases amongst the population, the line Ministries of Public Health and Sanitation and Medical Services in partnership with NGOs should continue combining efforts in advancing practical means for timely detection and response, prevent and control epidemics and by extension deaths. This partnership which should be strengthened to create friendly avenues that will pull the feelings and aspirations of the community into participating in on-going sensitization programs, among other health activities. There is need for the religious institutions and other development partners to sensitize the community on their basic rights and provide leadership in reaching out to community-based perspectives to local issues. This should continuously involve the youth, women and other vulnerable populations within the community as a way of empowering them with the necessary skills and knowledge that will make them participate in identifying and enforcing agreed-upon health priorities.

4. To address issues of accessing health services there is need for the government and other stakeholders to improve the local infrastructure. In addition, mobile services to offer first aid services should be established under health facilities with a view to reaching out to people who are within areas where roads are inaccessible during certain periods.
5. For the health policy makers, health practitioners and the NGOs operating in the study area, there is need for more feasible policies and / or programs that take into account consideration community health priorities. This will go a long way in empowering the community to realize its full potential. In addition, the policy makers, health practitioners and the NGOs should intentionally establish friendly appeal and publicity mechanisms that will integrate and incorporate both national health priorities and the aspirations and priorities of all populations including the marginalized groups and communities.
6. Further, there is need for a more accessible working and friendly communication strategy between the health committees at various levels and the community where ideas, priorities and other health concerns are communicated. This will also be an avenue for communicating the same from the Ministry of Health headquarters to the facilities levels at the community level and vice versa.
7. Further research should be conducted on mechanisms of fair priority setting and community participation. The focus should be on existing appeal mechanisms within the social structures in the community (as part of determining full conformance of the AFR conditions) with a view to making health priorities more viable and acceptable to majority of the populations in the community who are the outright consumers of the health priorities.

It is worth noting that the interventions arising from the above recommendations would be more relevant, fair and meaningful to the community if there is community participation in health priority setting processes as envisaged in the AFR framework.

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2. Gender of informant _____

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3. Describe the functions of your position and how the position affects priority setting in

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4. Describe the health priority setting structures that exist in your community?

7. How are general priorities made in your community? (Probe for priorities regarding health)

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9. Who is/are involved in health priority setting processes? (Probe for criteria used to be

World Bank (1993) *Trend in Developing Countries*. Washington D.C.

10. How are priorities made in your community? (Probe for criteria used to be

10. Who / what influences health priority setting processes in your community?

11. How are priorities in the health structures within the community made (such as dispensaries, health centres, hospitals)?

12. How do your priorities get communicated to the consumers (the community)?

13. Are your priorities relevant to the wishes of the community?

14. Who is involved in the implementation of the priorities? (Probe for community involvement)

15. Are there mechanisms put in place to challenge/revise the set priorities?

16. What are the factors that influence health priority setting in your community? (Probe for issues such as gender and leadership, age, religious affiliation, level of education, economic status, ethnicity, among others)

APPENDIXES

Appendix 1: KEY INFORMANT INTERVIEW GUIDE

1. Age of informant _____
2. Gender of informant _____
3. Position of informant in the community _____
4. How long has the informant held the position?
5. Describe the functions of your position and how the position affects priority setting in general
6. What are the health priority setting structures that exist in your community?
7. How are general priorities made in your community? (Probe for priorities regarding health)
8. Describe health priority setting processes in your community
9. Who is/are involved in health priority setting processes? (Probe for criteria used to be involved in the processes and the degree of involvement; participation of women, men and youth)
10. Who / what influences health priority setting processes in your community?
11. How are priorities in the health structures within the community made (such as dispensaries, health centres, hospitals)?
12. How do your priorities get communicated to the consumers (the community)?
13. Are your priorities relevant to the wishes of the community?
14. Who is involved in the implementation of the priorities? (Probe for community involvement)
15. Are there mechanisms put in place to challenge/revise the set priorities?
16. What are the factors that influence health priority setting in your community? (Probe for issues such as gender and leadership, age, religious affiliation, level of education, economic status, ethnicity, among others)

Appendix 2: FOCUS GROUP DISCUSSION GUIDE

The following themes were explored in the focus group discussions;

1. Community participation in health priority setting processes

- a) What are the priority setting processes in health at the community level?
 - b) What are the health priorities of the community?
 - c) What informs health priority settings in the community?
 - d) Who / What influence health priority settings?
 - e) Who participate in health priority setting processes?
 - f) Criteria for participation in health priority setting processes
 - g) Existing mechanisms for receiving priority settings and they are verified if they reflect the needs, wishes and / or feelings of the community
2. How does the community ensure that what it is getting / receiving is a true reflection of the decisions in priority settings?
3. How does the community ensure that its needs are reflected in health priority settings?

Appendix 3: CONSENT FORM

Title of the study: **Community Participation in Health Priority Setting in Magarini Division, Coastal Kenya**

Purpose of the study

The purpose of this study is to explore community participation in health priority setting processes in Magarini division in Coast Province of Kenya.

Confidentiality

Please note that no names will be used in the report or made public for any reason. In this regard, your name will not be mentioned anywhere in any report. All responses will strictly be kept confidential. Confidentiality will be maintained by using codes for identification of the persons interviewed and the interview transcripts. Only research team members will have access to the list of codes and the original data.

Participation and withdrawal

Your participation in this study is voluntary. Feel free to participate or withdraw from this study.

Procedures

If you agree to participate in this study, you will be requested to turn up for an interview whose duration will be about one hour. The main issues will be related to community participation in health priority setting. You are encouraged to ask questions or make

comments at any time during the interview. The interview / discussion will be taped and or notes taken.

Potential discomforts

The interview / discussion will take place according to your preferred normal working hours and will involve two researchers. You are required to give an appropriate time for the interview / discussion in order not to disturb your normal routine.

Potential benefits

There will be no direct benefits to you for your participation. But your contribution will help us to get a better understanding of community participation in making priority setting as far as health issues are concerned. The same will eventually go along way in improving quality, equity, accessibility and affordability of health care at community level.

Contact persons

Should you have any queries or concerns about this study, please feel free to contact the following;

Director,
Institute of Anthropology, Gender and African Studies,
University of Nairobi

Box 30197

Nairobi

Signature / thumb print of the participant

I understand the information provided above and that any questions or concerns I had have been answered to my satisfaction, and I agree to participate in this study.

Name of participant (use one name or initials)

Position of participant

Signature / thumb print of participant

Date

Name / signature of Researcher

Date