UPTAKE OF COMMUNITY HEALTH STRATEGY ON SERVICE DELIVERY AND UTILIZATION IN KENYA

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Abstract

Great Lakes University of Kisumu developed and tested a Comprehensive Primary Health Care (CPHC) model to facilitate the uptake of essential health services towards Millennium Development Goals (MDGs). The model focused specifically on the principles of intersectoral collaboration, community participation and empowerment to enhance access to health care. A study was undertaken in partnership with the Ministry of Health (MOH) to assess the implementation of the components of the model in different socio-demographic contexts in Kenya, and their relationship with health outcomes. This was a comparative, descriptive study which engaged the end users, policymakers, managers and communities in the design and implementation of research to enhance the utilisation of results. The CPHC intervention elements included: establishment of Community Health Units, governance and linkage structures, training of the health workforce, establishment of Community Based Information system and using it for regular dialogue at community and health facility levels leading to decisions and health actions.

Findings showed improvements in governance and management of the health system; service delivery and health outcomes such as immunization coverage, Antenatal Clinic attendance and health facility delivery.

Keywords: Community strategy, primary health care, community participation and partnership.

Introduction

By the 1990s, public choice theory had gained wide intellectual acceptance and displayed a strong centralized state could be predatory rather than benevolent. Economic failure and rural neglect in many countries were attributed to over-centralization and top-down approaches. The collapse of the Soviet Union strengthened the disillusionment with command systems and, in much of Latin America, military autocracies were replaced by democracies. These trends provided the political and economic impetus for decentralization that gradually became a new development fashion. Some countries saw it as a means of dismantling command economies, others as a tool for poverty reduction, still others as a path to grassroots empowerment (Aiyar, 2005a, b). After the debt crisis of 1982, the main focus of the World Bank shifted from poverty reduction to stabilization and structural adjustment programs via macroeconomic and sector policy reforms. However, by the end of the 1980s the adjustment programs were yielding many unintended consequences – the stern economic discipline had imposed significant losses and suffering on the poor. The World Bank progressively incorporated these approaches in its programs and two distinctly different approaches coincided: Community-Based Development (CDD) (where the community is consulted and involved, in varying degrees, by program managers) and Community-Driven Development (where the community is the fully engaged and empowered program manager). Indeed, the term Community-Driven Development was coined by Narayan & Binswanger (1995) to denote the integration of participatory approaches with decentralization and direct community empowerment.

Community Health Strategy (CHS) is an approach to health care service delivery in Kenya by the Health Sector as an effort to revitalize Comprehensive Primary Health Care (CPHC). The Great Lakes University of Kisumu in partnership with the Ministry of Health (MoH) Kenya engaged in promoting the strengthening of District Health Systems (DHS) by introducing a Comprehensive Community Based Health Care, and to demonstrate its effectiveness in improving the performance of the health system. The model was based on the concept of CPHC and focused specifically on the principles of Intersectoral collaboration (partnership), community participation and empowerment to enhance access to health care. After two years of implementation of the model in 6 pilot districts, an evaluation of the model revealed effectiveness in improving the performance of the DHS in terms of community participation, service delivery and health outcomes. The MoH adopted CHS and promoted its roll out throughout the

country. It was not known whether all the components of the strategy would be taken up by the health systems and implemented to the same degree in different socio-economic context, and by different stakeholders and with what results. The study objective was to assess the contribution of the implementation of CHS model on maternal and child health outcomes in the different socio-demographic contexts.

Literature review

The independent impact evaluation of the CDD project in Senegal, Programme National d'Infrastructures Rurales (PNIR), studied its impact on access to basic services, household expenditures, and child anthropometrics. It used a multidimensional panel data set to demonstrate significant effects on access to clean water and health services and decrease in child malnutrition (Arcand et al, 2007). The income generating agricultural infrastructure projects and enhanced primary education opportunities significantly increased household expenditures per capita, while hydraulic and health projects did not. Village chiefs and sub-regional politics were revealed to perform an important role in the determining which villages had access to the project. **Julien (2007)** examines ex-ante preferences of elected village's leaders and community members in Philippines concerning which project proposals received funding. The findings illustrate that the degree of involvement of households in the communal activities influences the likelihood that their preferences will be represented in the village proposals and that within a municipality resources flow to the poorest and more politically active villages. Controlling for poverty, the more unequal villages are more likely to receive funding. In the more unequal villages, the elected officials are more likely to override community preferences and influence the inter-village competition such that resources flow to their villages.

The study compares communities which received grants with control communities. It ascertains that participation in village assemblies, the frequency with which local officials meet with residents and trust towards strangers increased as a result of the project. However, there is a decline in group membership and participation in informal collective action activities, which may be due to time constraints or because the project improves the efficiency of formal forms of social capital and thus households need to rely less on informal forms (Labonne et al, 2008).

However, productive projects need outside markets to become sustainable and data on income and physical capital accumulation impact are not conclusive or statistically significant. There are transparent mechanisms which minimize political interference and elite capture. Social capital generated in communities and municipalities continues to increase even subsequent to project implementation. Jimat (2008) found a marked reduction in the prevalence of underweight children under five in the Masaf

villages, Malawi and a significant difference in improved access to water sources and sanitation in the villages that had road projects, with no explanation for any causal link here.

Kecamatan Development Program (KDP) in Indonesia influenced the local governance practices and community empowerment (McLauglin, 2007). It compared communities in KDP with different development programs within the same communities. Much depended on the location and local culture as Indonesia is large and diverse, but the role of the village head is crucial. Much more could be done to train the village head and village in more long term development planning, so the majority vote rules not against smaller and more marginal groups, but would allow such proposals to come in for later years. On the whole, KPD project compared to other development programs in the villages, are well implemented, more accountable and less corrupt and answer the needs of the people, although women are still mostly marginalized.

Scale up of community driven development

Local and Community-Driven Development (LCDD) is not a project, it is an approach that aims to empower communities with the resources and authority to use them flexibly, thus taking control of their development. Empowerment means the expansion of assets and capabilities of poor people to participate in, negotiate with and hold accountable institutions that affect their lives. It means giving people access to voice and information, greater social inclusion and participation, greater accountability, and organizational strength. LCDD aims to harness social capital through empowerment and increase social capital through scaling up. Well-functioning small-scale LCDD successes are a prerequisite for scaling up, but how scaling up proceeds from there depends on the context of the intended locations and country. While each situation is unique, the core philosophical underpinnings of LCDD are essentially universal. The complexities of scaling up, even for experienced practitioners, are multi-dimensional, daunting, challenging, and fascinating as well.

Primary health care (phc) in kenya

In 1970s there was a perception that ‘modernisation’ on its own, was not delivering dignified living for the majority of people. Primary Health Care (PHC**)** emerged from a realisation of the failure of the dominant medical model to meet major health needs of populations, it could treat disease for some but it couldn’t build health for all. PHC attempts to move beyond the boundaries of narrow bio-medical framework, including the idea of context into the picture of disease and health. It emphasizes the notion that technical ‘solutions’, pharmaceuticals and clinical interventions will not be adequate in improving health without creation of healthy environments. In Kenya, PHC started in the 60s but the first Community Based Primary

Health Care (CB-PHC) project supported by Ministry of Health (MoH) was implemented in Kakamega district, western province from 1974 to 1982. The project offered fresh ideas, mechanisms, strategies and approaches that could lead to essential health care for all (Were, 1984). Although MoH approved the PHC approach in 1982 and established a unit at headquarters known as Community Health unit to institutionalise it, no policy guidelines were elaborated to guide its implementation on a large scale.

When so much is at stake in terms of the policies to be adopted for the provision of health services in poor countries, it is important to clarify contributions of past health improvements and its role in the provision of health services in the future (Chen et al, 1993). This is the principle on which the evaluation of the Community Strategy (CS) was based. At individual and community levels, information is needed for assessing the extent to which services are meeting the needs and demands of the communities. Better availability and use of information has been shown to deliver cost savings, reduce systems inefficiencies and improve health outcomes (MOH, 2005). The utilization of available information by the community has received attention because it justifies among other factors, efforts by research and related organizations to improve people's activities and output (Wagner, 2000).

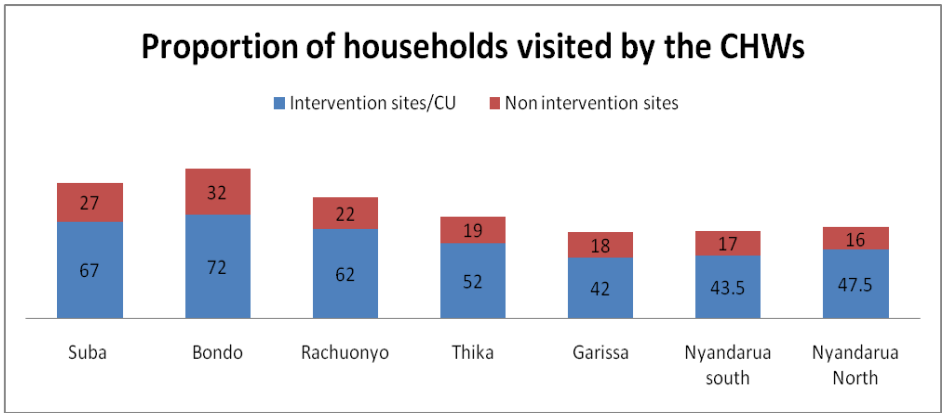
Methods

The study assessed the linkage of the health facilities to their Community Units (defined catchment areas). The study was a quasi-experimental design with a comparison of cross sectional (Baseline & Assessment) surveys. Qualitative data collection methodologies were essentially -3 Key Informant Interview (KIIs) with the District Medical Officers of Health, 14 Focus Group Discussion (FGDs) with the Community Health Workers (CHWs), 21 Health facility assessment (Community unit assessment), and a total of 270 client exit interviews done at each of the 12 health facilities. Quantitative data involved cross sectional household sample surveys. A total of 2800 households were interviewed for each district, 300 from households from intervention sites compared with 300 households from the non-intervention sites. Quantitative data analysis was done using SPSS while qualitative data was content analyzed under themes and sub themes emerging from coded transcripts. There were intra district comparing the 3 different regions Butere district (Rural agrarian), Nyalenda (peri urban slum) and Garissa (nomadic region). It also focused on length of implementation of the CHS and lastly a comparison across the 3 provinces to contextual differences in the uptake and implementation of the strategy. The criteria for the level of implementation of the CHS was based on five elements, the establishment of Community Units (CUs) the proportion of CUs, Establishment of governance and management structures-Community health

committees (CHCs), Health Facility Management Committees (HFMCs) and District stakeholders Forum (DHSFs).Proportion of trained and active Community Health extension workers (CHEWs) and CHWs.

Results

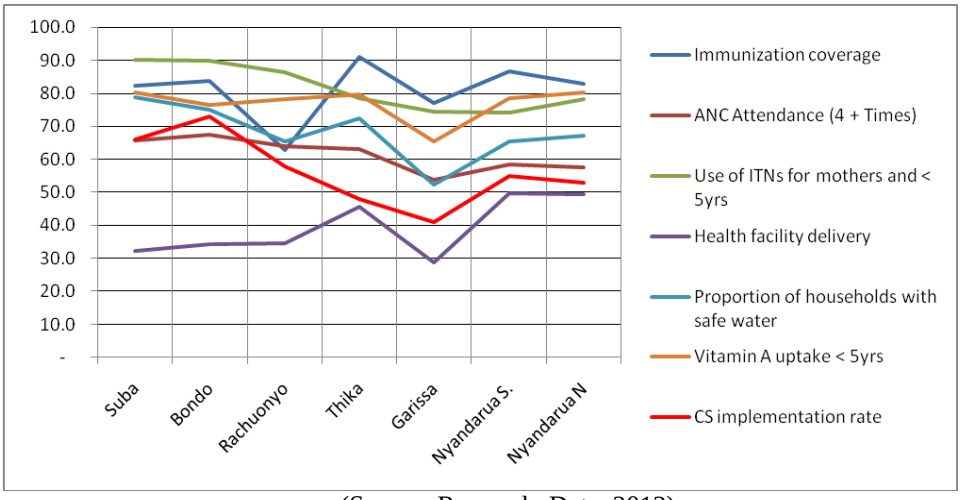
Figure 1: proportion of households reached through dialogue during the CHWs home visits.



(Source: Research: Data, 2012)

The level of proportion of the household visits reflects the degree of dialogue of CHWs with the household members. Implementation of the uptake of CHS on the quality of health service delivery and outcome was noted to have made a difference in the quality of Health service delivery.

Figure 2: A graphical correlation between the Community Strategy implementation and Maternal and Child Health indicators



(Source: Research: Data, 2012)

According to Fig. 2, strengthened governance particularly community health committees and stakeholder forums have influenced antenatal care

(ANC) attendance (4 + Times) (r=0.750) and use of ITN's for mothers (r=0.906) and children under five strongly. CHW's relate strongly to the output on the use of insecticides treated nets (ITNs) for mothers and children under 5 years (r=0.615), households with safe water(r=0.600) and vitamin A uptake for children under 5 years (r=0.734). Average results are showing for ANC Attendance (4 + Times).

Conclusion

CHS performs a key role in the renewal of comprehensive PHC in Kenya. It improves access to health care thus improves health service indicators. Involvement of the community in planning (Community Participation) has started to attract levels of resource allocation to the lowest level of care, leading to equitable distribution of resources, supported by this integrated approach to a multidimensional and multisectoral health programme. It ensures community's increased access to most health services and has shown that most of the components can be taken up and sustained in different socio-demographic contexts leading to improvement in performance. Certain health outcomes such as health facility delivery did not improve as the others and may need an in-depth study to determine causes to help design additional intervention elements that can improve both demand and supply aspects. There should be continuous supervision and close linkage at all system levels. As demand is created in the community for health services, there should be readiness to provide the services at the health facilities.

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