Between Communities and Health Facilities in Health Service Delivery

Reality or Myth?

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1 Background

Health service delivery remains a challenge for rural Kenya. Health sector reforms have come at a time when various models are being tested to improve access and utilisation of health services offered by various providers, i.e. NGOs, government, private practitioners, etc. World Neighbours[1] has been testing a model that emphasises the participation of local people, initially through working with a non-formal health provider (traditional midwives), then fostering and nurturing relationships between the non-formal and formal health providers, and their institutions.

This article will examine the model in light of trends in health service delivery from the 1970s to date, comparing policy trends to the reality on the ground. A case study raises questions such as: Can the voices of the communities influence the quality and type of services? Can communities access and use services offered by facilities where they cannot influence management, staffing or supplies? Can vulnerable people access services where they have to pay?

2 Policy Environment and Ground Realities

Over the course of the last twenty years, there have been significant shifts in health policy and ground realities. In the 1970s, government service provision of free health care met the problem of low demand. The increasing involvement of NGOs in community-based health care increased participation in health service delivery, helping to increase demand for services. The shift to decentralised management and the introduction of fees for health services imply changes in the nature of community involvement. The table over illustrates some of these shifts in macro policy and micro ground realities. As we go on to discuss, these changes present a series of new challenges for the provision of Primary Health Care (PHC) at the local level.

[1] World Neighbours is an international non-profit NGO. Its goal is to strengthen the capacities of marginalised people to meet their basic needs and participate in an inclusive development process. World Neighbours operates holistic programmes which incorporate food security, family health, water provision for household and livestock and support for economic initiatives.

Table 1: Macro level and micro ground realities: changes over time

Year	Macro Level	Micro Ground Realities	
1970s	Supermarket concept for health MCH/FP	GOK – Demonstration health centres in the districts	Free services – low demand
1978	ALMAATA Conference PHC essentially top–down	NGOs adopt idea start CBHC – encouraging participation in health service delivery	Free services – low demand
NGO/GOK set up Community Health Unit at MOH to harmonise and rationalise implementation			
1980s	Expanded proramme on immunisation and HIV/AIDS	NGOs – CBHC programmes very active in implementation	Free services – increasing demand
1985	Essential drug supply - BI/UNICEF-driven	Bamako Initiatives started, sustainability issues not addressed	Free services – increasing demand
1990	Health Sector Reform	Service fees in public facilities. Decentralised management: communities not prepared to understand roles. Confusion – minimal accountability although people pay for services	Cost sharing – steady demand

3 Partnerships for Health Improvement

World Neighbours started working in Makueni District in 1988, through an adult education class. The main activities of this group were:

- Assisting one another to improve family shelter by roofing houses with iron sheets
- Roof catchment for household water
- Organising training which responded to their needs, for example agricultural production and midwifery skills.

As the above activities were being carried out, the group felt that even though traditional midwives' skills had been upgraded through training, this was not enough. Some pregnant women walked many kilometres (10–30 km.) before getting transport to the hospital 100 km. away.

The traditional midwives and the adult education group analysed the problems of service access for women. They felt there was a pressing need for a maternity ward where women could deliver safely and pregnancy complications be dealt with. After discussion with the rest of the community, a joint decision was taken to extend the local, government-staffed and -supplied dispensary that the community had set up, to include other services, like child immunisation, family planning and maternity services.

World Neighbours saw an opportunity to work with this community to improve these health services. The adult education group, the traditional midwives and other community members in the villages surrounding the dispensary were assisted in carrying out an in-depth analysis of the existing health services, to identify the gaps and develop an action plan. The analysis revealed that the local

community had a dispensary, traditional midwives and privately operated clinics. They lacked immunisation and family planning services, a maternity clinic for referral and community outreach. Importantly, the community noted that they lacked voice in decision-making on how the dispensary would be run, quality of services, staffing and acquisition of supplies. Although they had put up the building for operating the dispensary their role seems to have ended with the starting of services at the dispensary.

From this analysis arose an action plan that sought to address these concerns. It included three key elements. The first was the election of a Health Management Committee (HMC) that would be linked with the dispensary. Second, the action plan focused on developing and strengthening links with the Ministry of Health at the district level (the District Health Management Team – DHMT) and with World Neighbours for technical and material assistance. Lastly, resource mobilisation for improving the health services was addressed.

The elected committee undertook training on their roles, led by World Neighbours. These included planning for the future expansion of the services: both physical infrastructure and outreach services, linking the services at their locality with mainstream health services through the DHMT, and planning and implementing mechanisms for both local and external resource mobilisation and management to meet their objectives.

The local HMC met with the DHMT and World Neighbours and a series of changes were agreed. Immunisation services would be operated from the dispensary, which would be upgraded to a health centre and provided with an extended drugs kit. Community health workers and community-based distributors of contraceptives would be trained. Growth monitoring centres in the communities served by the dispensary would be started and supported from the newly upgraded health centre. The dispensary building itself would be extended to provide adequate space for the additional services.

Accessibility of the services to the vulnerable was a further issue. Free services would be available to the most vulnerable, but how were these vulnerable people identified? One problem was that the local HMCs often did not know who the vulnerable were, as they serve such a widespread population. This problem was addressed by forging links with village institutions where well-being ranking had been carried out, so that the vulnerable could be more easily identified.

The services were put in place between 1991 and 1997. Outreach services operated by community health workers now include three growth-monitoring centres, community-based distribution of contraceptives, health education and sanitation. Operation of these services, however, has met with one major challenge: the irregularity of key supplies such as vaccines, contraceptives and essential drugs.

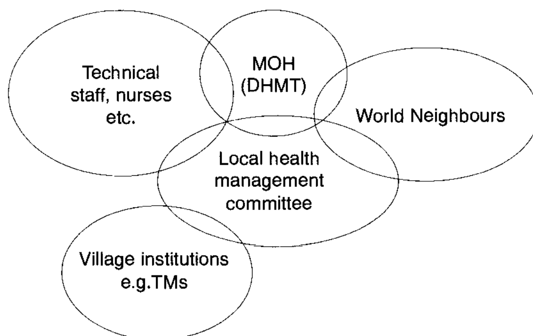
4 Emerging Issues

4.1 Management and decision-making over the type of services provided

The experience of this case study shows that communities can influence the type of services provided, if they understand their rights and responsibilities concerning their own health and services. There also needs to be a conducive macro-level environment to tie in with micro-level realities. What emerges most powerfully from this experience is the importance of involving communities directly in the analysis of their own health situation, using participatory processes and tools.

Shifting the focus from looking only at the provision of public health services to communities' use of available providers opens up the possibility for strengthening the services that exist. This case shows that community/demand-driven accountable health services can emerge through nurturing existing health services, some of which may be non-formal. In this instance it was nurturing the traditional midwives' service that led to improved local health services. Yet the community can only influence the type of service where they have a stake in it. The management of private clinics, where the local people view themselves only as consumers, has not been influenced. In this case, the private clinics, though they have been in existence as long as the local dispensary, have not changed their services to reflect local needs.

Figure 1: Institutional interactions



A number of challenges arise for effective community influence over the provision of public services. As health centre staff are employees of the MoH, staff are upwardly accountable to the MoH and not the local HMC. In the current context of health sector reforms there is some opportunity for local level responsibility for supervision of staff, but it is critical that technical staff should come to understand that they are accountable to the local HMC committee as well as the DHMT. Experience in Makueni has shown that interactive communication is essential. Dialogue must be fostered between the various parties, in this case between the DHMT, local management committees and staff, in order to reach consensus on decisions. Mechanisms should be in place to enable communication between the management committee and staff at the local level, and the DHMT at district level. This communication nurtures the evolving relationships that form the foundation for participation and an evolving partnership. Figure 1 illustrates interactions between the different interest groups and institutions involved, in which the local HMC lies at the centre.

4.2 Management and decision-making over quality of service

The quality of services is affected by several factors. A key factor is local service users' understanding of their rights and responsibilities with regard to health service delivery. In order for users to be able to engage effectively with decentralised management systems, they need access to information that sets standards in terms of what the local community can expect from the health facility. A further factor involves the selection and preparation of staff who are expected to provide services in an environment that differs to a large degree from the environment where training of staff is provided, for example where there is no running water, electricity supply and so on. Regularity of supplies such as essential drugs, immunisations, contraceptives and dressing materials is vital if services are to be delivered effectively. Lastly, decision-making and allocation of resources have important implications for the quality and scope of the services provided by local health services.

The extent to which communities, through their management committees, are able to exert an influence over the quality of care provided to them depends on how their roles and responsibilities are defined. In the case presented the local management committee was able to influence the public health service regarding types of services they needed locally. Yet they were not able to monitor effectively or exert much influence over the quality of local services, because the local management committee is viewed as responsible principally for providing the physical infrastructure. The local management committee is unable to hire or fire staff. Its role effectively ends at submitting reports and recommendations in terms of staff performance, and it has little opportunity itself to act on their findings.

Equally, the local management committee has no influence or control over the timing and quantities of supplies for the local health service. The medical officer is responsible for this, following policy

guidelines. The effects of this lack of influence have a direct bearing on community health, as is evident from the statement of one of the clients who suffered, due to irregular supply of contraceptives: 'I was just unfortunate. I became pregnant because the day I went to replenish my contraceptives they were not available'.

It can be strongly argued that a local management committee, if given the mandate, can influence both type and quality of service. In this case, the quality was not influenced because the decision-making over the factors that determine quality as well as information was held by the government department and not shared with the committee.

4.3 Quasi-community ownership

Quasi-community ownership is, in effect, when the government encourages local people to provide the physical infrastructure, while its Ministry of Health provides staff and supplies. While this arrangement has enabled many rural Kenyans access to some form of health service, it also creates some difficulties.

It is not clear who owns the facility, i.e. the community or the government. It is also unclear in terms of roles who has the final say in any serious matter, or in management. If government fails to provide the supplies, the community is unable to influence this. Having invested in mobilising funds, they have now to spend further funds buying private curative services, and miss out on immunisations and contraceptives, which private practitioners do not provide. Communities remain reliant on government to provide staff. Where the government fails to do this, the investment the community has made in building and maintaining physical structures is wasted, and they are useless.

5 Conclusion

The model applied by World Neighbours of nurturing an evolving local health service from a non-formal service, using participatory methods to foster institutional relationships, and responding to demand-driven service needs has worked to improve the types of services provided. However, the partnership was not broad enough to incorporate private practitioners, and has not fully addressed the challenge of quality of services. The local health management committee needs to strengthen its management capacity in order to be able to handle new responsibilities that are resulting from the health sector reform, and also to tackle issues relating to quality of services. Problems of staffing, and regularity of supplies, such as essential drugs, contraceptives and other equipment, have to be addressed for this model to work well. In the absence of such attention local people's efforts and participation are wasted as far as health service delivery is concerned.